DESERT VALLEY PEDIATRICS

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Authorization for Disclosure of Protected Health Information (PHI)

-General

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION REGARDING MY CHILD/OR MYSELF AS DESCRIBED BELOW FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

Patient Name: _____ Date of Birth: _____

A. Person(s) authorized to bring the above named child to Desert Valley Pediatrics and Provide, Use or disclose the information, i.e.: Family Members, Nanny, Step-Parents.

1. _____
2. _____
3. _____

B. Person(s) or Organization(s) authorized to **Receive** the information, i.e.: Clark County School Districts, Daycare Centers or Others.

1. _____
2. _____

C. Specific description of the information, i.e.: Labs, X-rays and/or all Medical Records.

_____

D. This authorization will expire on _____ (leave open or enter a date)

I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Desert Valley Pediatrics in writing.

I may inspect or copy any information used or disclosed under this agreement and I have the right to receive a copy of this form.

I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

I understand that this form does not constitute legal advice and covers only federal, not state laws.

_____ _____

(Signature of Patient or Patient's Representative / Relationship to Patient) Date

I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).

Signature _____ Date _____