

13055 W McDowell Rd, Suite E-106
 Avondale, AZ 85392
 Phone: (623)975-8400 Fax: (623)935-2975
 www.lalomaonline.com www.lalomakids.org

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

I authorize: _____
(Name of person, facility, or class of persons which has information)

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

To release records to: _____
(Name of person, facility or class of persons which has information)

Address: _____

City: _____ State: _____ Zip Code: _____

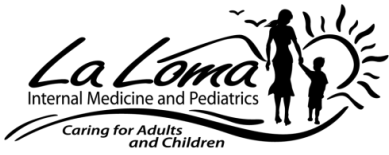
Phone: _____ Fax: _____

TYPE OF INFORMATION TO BE RELEASED

- | | |
|---|--|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Genetic Testing Information |
| <input type="checkbox"/> Billing Statements | <input type="checkbox"/> Emergency Medicine Records |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> History and Physical Exams |
| <input type="checkbox"/> Outpatient Clinic Reports | <input type="checkbox"/> Radiology and Other Diagnostic Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Psychological/Vocational Test Results |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Mental Health Information |
| <input type="checkbox"/> EKG Reports | <input type="checkbox"/> Communicable Disease Information Including HIV/Aids Information |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Drug and Alcohol Abuse Information | |

THE PURPOSE OF THE RELEASE IS (Check one or more):

- For the Patient/Patient Representative's Personal Use of Records
- Continued Patient Care
- Worker's Compensation
- Insurance Coverage or Payment for Care
- Other (State Reason): _____



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NOTICE:

La Loma and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your medical records, you are protected by state and federal confidentiality laws.

MY RIGHTS:

- I understand that this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. One exception is if you come to La Loma for an employer physical or other treatment where the purpose is to create health care information for a third party. In that situation we cannot treat you if you do not sign this authorization.
- I may revoke this authorization at any time, with some exceptions provided that I do so in writing and submit the request to La Loma Internal Medicine and Pediatrics. The revocation will take effect when it is received except into the extent that La Loma or others have already relied on it
- I am entitled to receive a copy of this authorization.

Expiration of Authorization:

Unless otherwise revoked, this authorization expires _____ (Insert applicable date or event). If no date is indicated, this authorization will expire 90 days from the date of signing this authorization.

I understand the matters discussed on this form. I release La Loma, its employees, agents, disclosure of the above information to the extent indicated and authorized herein.

Signature: _____ Date: _____
(Signature of Patient or Patient's Representative)

(Printed Name of patient or Patient's Representative)

If signed by someone other than the patient, state your relationship to the patient and your authority to act for the patient. (Please attach evidence, if appropriate).