La Loma
Internal Medicine and Pediatrics
Caring for Adults and Children

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

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

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 extant 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).