PONDEROSA PEDIATRICS

6512 S. McCarran Blvd, Suite D
Reno, NV 89509
Phone: 775-900-9987
Fax: 775-900-9954

Authorization to Release or Disclose Protected Health Information

Patient's Name: _____ Date of Birth: _____ Date of Request: _____

Address: _____Phone: _____

Please check the box which best defines your need:

☐ Request Medical Records **FROM:** ☐ Send Medical Records **TO:**

Facility Name: _____Fax Number: _____

Address: _____ Phone Number: _____

Dates of Service: _____ Email Address: _____

Reason for Request: _____

The following information is to be disclosed <u>TO</u> Ponderosa Pediatrics <u>OR</u> _____.

Problem List	Immunization Record	Medication List	Last Well Visit
Growth Charts	Drug Allergy History	**Entire Medical Record**	

- I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.
- I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.
- I understand that authorizing disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.
- Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I do not specify an expiration date, event or condition, this authorization will expire in 6 months from the date signed.

By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Ponderosa Pediatrics of any and all accountabilities concerning the release of these medical records.

_____ _____

Signature of patient or legal representative Date

_____

If signed by a legal representative, relationship to patient