

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION  
(Medical Release Form)**

I, \_\_\_\_\_, authorize the disclosure of my child/children's protected health information (medical records) as described herein.

Childs Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my child/children's protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and /or organization(s) to disclose my child/children's protected health information (as specified below):

**Mountain View Pediatrics  
77 W. Forest, Suite 304  
Flagstaff, Arizona 86001  
(928)214-3600 Fax (928)214-3601**

2. I authorize the following person(s) and/or organization(s) to receive my child/children's protected health information (as specified below):

Name(s): \_\_\_\_\_

Organization(s): \_\_\_\_\_

Address: \_\_\_\_\_

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

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4. Specific description of the purpose for each use of disclosure (or write "at the request of the individual" in this place)

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5. I understand that I may revoke this authorization at any time by sending a letter to the person or organization listed in paragraph one, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization. If I do not sign this form or if I later revoke my authorization, the services provided to me by the person or organization listed in paragraph one will not be affected in any way.

This authorization expires on: \_\_\_\_\_

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

\_\_\_\_\_  
**Signed** **Date**

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Social Security:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_