Mountain View Pediatrics
77 West Forest Avenue, Suite 304
Flagstaff, AZ 86001
(928) 214-3600

Patient Name: _____
Date of Birth: _____
Parent/Guardian Name: _____

Authorization for Release of Protected Health Information

Mountain View Pediatrics standardly releases **1 complimentary** set of the most recent 2years of medical data. If you are requesting additional information or an extended time frame, please specify below in the additional comments section. A $15 fee may be applied outside of the standards above.

As a reminder- most medical information is accessible through our portal @ www.mvpeds.com - click "Patient Portal"

I_____, authorize Mountain View Pediatrics to process my child's protected health information as specified below:

To **RECEIVE** ☐ And / Or **DISCLOSE** ☐ My child's protected health information

To receive from or disclose to: ☐ Self ☐ Other (specify below)

Person(s)/Facility Name: _____

Address:_____City_____State_____Zip_____

Phone Number:_____Fax Number:_____

Email Address:_____

Mail: ☐ Fax: ☐ Email: ☐ Paper copy: ☐ Disc: ☐

Please check if you would like the following released in addition to the general medical information:

Mental Health ☐ Drugs/Alcohol ☐ HIV/AIDS ☐ Genetic Testing ☐

Specify the purpose of this request:_____
(Moved, Transferred Care, Care Coordination, etc.)

Additional Comments / Requests:_____

_____

I understand that I may revoke this authorization at any time in writing 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.

The authorization expires on:_____ *Valid for one year, if no date is provided*

_____
Patient's Name

_____ _____
Print Name of Parent or Legal Guardian Date

_____
Parent or Guardian Signature