CATALINA PEDIATRICS   FAX # 520-323-3460

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name ____ Account # ____________________

Former Name(if any)________________________________ Social Security # _________________

Daytime Telephone # _______________________________ Birthdate _________________________________

INFORMATION TO BE RELEASED FROM

I hearby authorize (name of organization)____

to release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physican/Organization/Person **Street Address** **City/State/Zip**

___________________________________ ________________________ ________________________

Phone:_____________________________ **Fax#:**___________________ ________________________

PURPOSE OR NEED FOR THIS INFORMATION (PLEASE CHECK A BOX)

- ☐ **Moving** ☐ **Specialist Appt** ☐ **Dissatification** ☐ **Change of Insurance Plans**
- ☐ **Other(specify)** ____

TYPE OF INFORMATIONTO BE RELEASED (No Information will be relased unless a box is checked)

General Release **DATES OF TREATMENT**

☐ **Medical Records/Excluding Protected Records** **From** __________ **To** _____________

(this will be limited to 1 year of information inculuding **From** __________ **To** _____________

Labs,X-ray Reports unless otherwise stated)

☐ **Other Records (specify(** _____________________________________

Information Protected by State/Federal Law

☐ **Drug Abuse Diagnosis/Treatment** **From** __________ **To** _____________

☐ **Alcholism Diagnosis/Treatment** **From** __________ **To** _____________

☐ **Mental Health Diagnosis/Treatment** **From** __________ **To** _____________

(may include treatment of pain management and center women's health or psychiatry)

☐**Sexually Transmitted Diseases Diagnosis/Treatment or Counseling** **From** _________ **To** _____________

(includes AIDS/HIV)

☐ **Communicable Diseases and Related Information** **From** _________ **To** ______________

☐ **Genetic Testing Information** **From** _________ **To** ______________

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing writtien notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understands that it is pohibited from making any disclosures of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise premitted by applicable law.

_____________________________________ _________________________________

Signature of Patient OR Legal Represenative **Please Print Name of Sigining Party**

____

Date Signed

Patient Requesting Medical Records Copy $10.00 for the first page,each additonal page .20 ¢ Total _________# of Pages ___________

NOTE: If this request is made by mail, this office requires the request be notarized by a State Notary Public