AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

PLEASE, READ THOROUGHLY: (NOTE: PROVIDE ACCURATE & COMPLETE INFORMTION. **EXAMPLE:** IF THE DOB IS INCORRECT, THIS CAN DELAY PROCESSING YOUR REQUEST)

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/ Organizations providing the information:	**Persons/ Organizations receiving the information:** >>>**Please Provide a Phone number, FAX No. & Address<< * please print clearly and legibly**
Journey Pediatrics 8308 Constitution Pl. NE, Albuquerque, NM 87110 Ph: (505) 883-9570 / **FAX (505) 883-4163**	
Specific description of the information:	**Purpose of requested use or disclosure:**
□ **All Records (Provide your address & a Phone #)** □ History and Physical □ Laboratory Reports □ Radiology Reports □ Progress Notes □ Other_____	□ Continuing Care □ Insurance Information □ Attorney Use □ **Personal Use (Provide your address & Phone #)** □ Other _____ □ **Moving (Provide your New Address & a Phone Number)**

Moving/address: _____

The patient or the patient's parent/guardian must read and initial the following statements:

Initial each box below

1.	I understand that this authorization will expire on _____ /_____ / _____. If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

Date, sign and print first and last name.

_____ _____

Signature of Patient or Parent/ Guardian **Date**

_____

Printed Name of Parent/ Guardian (please print clearly and legibly)

This document will be retained by the providing organization for six years.