

Patient Authorization To Transfer Medical Records Or Disclose Other Protected Health Information to Gateway Pediatrics P.L.L.C.

By signing this authorization, I authorize release of medical records of the following:

_____ whose DOB is _____
Name of Patient **Date of Birth**

From:

Office Name: _____

Doctor's Name: _____

Address: _____

Phone#: _____

Fax#: _____

To:

**Gateway Pediatrics P.L.L.C.,
 205 S. Dobson Road, Suite # 1
 Chandler AZ, 85224
 (Phone 480-963-6668, Fax 480-963-6669)**

Please transfer and/or disclose the following information:

All Medical records, files, charts, reports and other associated health information

OR

The following specific Protected Health Information (PHI)(check all that apply)

Medical Records & Charts Immunization Records X Rays or Diagnostics

Lab Results Others (Please specify)_____

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I do not have to sign this authorization in order to get health care benefits. I understand that that I have the right to revoke this authorization at any time in writing, except to the extent that that the medical provider named above or Gateway Pediatrics PLLC has acted in reliance upon this authorization.

Name of Parent/Legal Guardian			
Relationship to Patient			
Address			
City	State	Zip	Contact Phone
Signature			Date