CACTUS PEDIATRIC ORTHOPAEDICS

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the release/request of copies and/or discussion of the specified information included in my medical records that are in your possession. I understand that record requests may take up to 5 business days to process. Furthermore, I understand that if my request lacks any of the information requested below, the processing time may be significantly delayed.

Description of information to be released/ exchanged/ obtained:
☐ All healthcare information OR ☐ Healthcare relating to the following treatment, condition, or dates:

_____

Authorized Release by way of: ☐ Email ☐ Paper Mail ☐ Faxed records ☐ Verbal/Exchange of information

Purpose of Release: ☐ Continuity of Medical Care ☐ School ☐ Personal Use ☐ Legal

Release of information ☐ To Cactus Pediatric Orthopaedics from / ☐ From Cactus Pediatric Orthopaedics to:

Name of Person / Agency / Institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

I certify that this request has been made voluntarily and that the given information above is accurate to the best of my knowledge. By my signature below, I further declare that I have the legal authority to grant the above permission. I understand that I have the right to revoke this authorization, provided that I do so in writing, except to the extent that Cactus Pediatric Orthopaedics has already used or disclosed the information in reliance to this authorization. I understand that once the records and information authorized herein are disclosed to entities or persons outside of Cactus Pediatric Orthopaedics, they could be re-disclosed by the recipient(s) and may no longer be protected by the Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 and/or other state or federal laws and regulations. **THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.**

Patient/Parent/Legal Guardian Printed Name: _____ Date Signed: _____

Parent/Legal Guardian Signature: _____