Desert Willow Pediatrics

Joy Peskin M.D., F.A.A.P

6369 E Tanque Verde Rd, Ste 190

Tucson AZ 85715

Authorization to Release Medical Information (ROI)

Please Print

Patient Name: _____
Date of Birth: _____
Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

*Please Do Not Fax Records

I, the undersigned, consent to the release of medical information (records)

To/From: **(Circle one)**
Desert Willow Pediatrics
Joy Peskin MD
6369 E Tanque Verde Rd, Ste 190
Tucson AZ 85715
(520)751-4124/Fax: (520)751-0337

To/From: **(Circle one)**
_____
_____
_____
_____
_____

Information to be released: _____

*In addition to the general authorization to release medical records, I further authorize release of the following information, if it is contained in my medical records: **(please initial each appropriate line)**

	May be released	**May NOT be released**
Drug and alcohol abuse:	_____	_____
Mental Health:	_____	_____
Diagnosis/treatment of HIV, HIV related Illness, AIDS, AIDS related illness, communicable Disease related information	_____	_____

Dates of treatment: _____ to _____ (**If not specified, this will be limited to 1 year of treatment**)

Purpose of disclosure: _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE after **six months** (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 written 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 prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.**

*There is fee of **$0.25 per page or $10 for a CD** for records released to patients or their representatives. The fee is waived if releasing to another provider.

_____
Signature of (Patient, Parent, Legal Guardian, or Legally Authorized Representative)

_____ _____
Date Signed Printed Name of Person Signing

***Records will be made available within 30 days of receiving the request.** *** Rev 9/2018**