



Authorization for Release of Medical Information

Patient name: _____ Date of birth: _____

I hereby authorize the entity listed below to release medical information to Desert Bloom Pediatrics:

Doctor/Clinic/Hospital: _____

Address: _____

Telephone: _____ Fax: _____

Send records to Desert Bloom Pediatrics

8352 W. Warm Springs Rd, Suite 210, Las Vegas, NV 89113

Phone: (702) 551-1765 Fax: (833) 455-9871

Records requested

- ☐ All records permitted by this authorization
☐ Records dated from _____ to _____
☐ Immunizations and physical examinations ☐ Radiology reports
☐ Other records: _____

Do not release the following information:

Selected records may include mental health and HIV-related information, unless excluded above. This form does not authorize release of separately maintained psychotherapy notes or substance use disorder records subject to 42 CFR Part 2, including substance use counseling notes. Request a separate appropriate authorization or consent for those records.

Authorization and patient rights

I authorize the provider identified above to disclose the selected records to Desert Bloom Pediatrics for treatment and continuing care. This authorization expires one year after the date it is signed.

I may revoke this authorization at any time by sending a written revocation to the provider releasing my records at the address listed above. Revocation does not affect disclosures or other actions already taken in reliance on this authorization.

Signing is voluntary. Treatment, payment, enrollment in a health plan, and eligibility for benefits will not be conditioned on signing this authorization. Information disclosed may be redisclosed by the recipient and may no longer be protected by HIPAA.

I am entitled to a copy of this signed authorization.

The patient signs if age 18 or older, emancipated, or legally authorized to control disclosure of the requested records. Otherwise, an authorized parent or legal representative signs.

Patient / authorized representative signature: _____ Date: _____

Printed name: _____

Signer: ☐ Patient ☐ Parent ☐ Legal guardian ☐ Other authorized representative

If representative, relationship and authority to act for patient: _____