8285 W. Arby Ave.
Suite 255
Las Vegas, NV 89113

OASIS PEDIATRICS

Phone: 702-476-2944
Fax: 702-476-2958
www.oasispediatrics.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (NEWBORN)

Newborn #1: Last Name _____ First Name: _____ DOB: _____

Newborn #2: Last Name _____ First Name: _____ DOB: _____

Birth Mother: Last Name _____ First Name: _____ DOB: _____

I HEREBY AUTHORIZE THE RELEASE AND DISCLOSURE OF THE INFORMATION DESCRIBED BELOW:

Please check the information to be disclosed:

- ☐ Complete Records
- ☐ Newborn/Birth Records
- ☐ Hospital Discharge Summary
- ☐ Other: _____
  _____

PLEASE SEND RECORDS TO:

OASIS PEDIATRICS
Address: 8285 W. Arby Avenue, Suite #255
Las Vegas, NV 89113
Phone: 702-476-2944 Fax: 702-476-2958

TRANSFER RECORDS FROM:

Facility / Physician Name:	Phone Number:	Fax Number:	
Address	City	State	Zip Code
Facility / Physician Name:	Phone Number:	Fax Number:	
Address	City	State	Zip Code
Facility / Physician Name:	Phone Number:	Fax Number:	
Address	City	State	Zip Code
Facility / Physician Name:	Phone Number:	Fax Number:	
Address	City	State	Zip Code

I understand there is a fee to release medical records to a legal parent/guardian for personal use. Hard copies are provided for .60 cents per page. Medical records CANNOT be emailed to parent/guardian for personal use.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance. I understand that once the health information is disclosed, it may no longer be protected by federal privacy law if received by a non-medical facility. This authorization is valid for one calendar year from the date signed. Only records from Oasis Pediatrics can legally be released. Any record from another physician must be obtained from them directly.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____