Phoenix Pediatrics

4434 N. 12th Street
Phoenix, Arizona 85014
Telephone (602) 242-5121
Fax (602) 242-6945

4735 E Union Hills Drive
Phoenix, Arizona 85050
Telephone (602) 971-5121
Fax (602) 971-3122

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

INSTRUCTIONS: Complete this form in its entirety. Please complete a separate form for each individual requestor. If you have questions please call and ask to speak to Medical Records.

Patient Name	Date of Birth		
Address	City	State	Zip Code
Requested By	Phone number		

I authorize the information to be disclosed to:

Individual/ Entity	**FAX number***		
	Phone number		
Address	City	State	Zip Code

Purpose of the release is: ❑ Immunizations only ❑ Personal use of records ❑ School ❑ Continuing medical care ❑ Disability ❑ Attorney office ❑ Insurance ❑ Other: _____

I hereby authorize the release of medical records ❑ TO ❑ FROM Phoenix Pediatrics at the above address.

Please release the following:

❑ Recommended for Continuing Care: Progress Notes, (2 years), All Lab/Test Reports, Immunizations, Growth Charts, Specialist Reports

❑ Legal: All records

Notice: Phoenix Pediatrics is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by State and Federal confidentiality laws. For the purposes hereof, Medical Records shall include all confidential HIV-related information, communicable disease, alcohol or drug related information and mental health diagnosis/treatment information.

My rights: I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time, with some exceptions, provided that I do so in writing and submit the request to Medical Records. The revocation will take effect when Phoenix Pediatrics receives it, except to the extent that Phoenix Pediatrics or others have already relied on it.

This authorization will expire automatically six (6) months from the date signed. I understand the matters discussed on this form. I release Phoenix Pediatrics, it's employees, agents, officers, directors and medical staff from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Legally Authorized Representative | Date

_____ _____

Printed Name of Patient or Legally Authorized Representative | Relationship to Patient