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Payment of $25.00 per child is required prior to copying records.
Records released to another physician will be free of charge.

MEDICAL RELEASE

Patient's Name(s) Patient's Date of Birth(s)

_____ _____
_____ _____
_____ _____

PLEASE PROVIDE DOCTORS NAME, ADDRESS AND PHONE NUMBER

Doctor's office to PROVIDE information: Doctor's office to RECEIVE information:

_____ _____
_____ _____
_____ _____
_____ _____

Information Requested:
____ Immunizations Only ____Labs/X-Rays ____ALL Medical Records
____Progress Notes : Dates from _____ to _____

I authorize the release of photocopies of the following medical records in the possession or control of Pediatric Associates, P.C., it's employees or agents. FOR THE PURPOSES OF HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 39-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.
This consent will expire (60) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Pediatric Associates, P.C. in writing to affect that. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that photocopy of this authorization is considered acceptable in lieu of the original.

Patient or Legal Guardian's Signature Date

Printed Name Relation to Patient

Your Contact Information

Address: _____

Phone Number: _____