Pediatric Associates, P.C

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AUTHORIZATION FOR RELEASE OF INFORMATION

**** Payment of $25.00 per child applies. Records released to another physician well be free of charge****

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

Address: _____ City: _____Zip Code: _____
Phone Number(s): _____

RECORDS LEAVING PEDIATRIC ASSOCIATES, P.C

[ ] I hereby authorize Pediatric Associates, P.C. to release the information specified below from the medical record(s) of the above named patient(s).

Recipient of Records: _____

Address, City, State, Zip Code: _____

Phone number: _____ Fax #: _____

OR

RECORDS BEING SENT TO Pediatric Associates, P.C

[ ] I hereby authorize _____ to release the information specified below from the medical record(s) of the above named patient(s).

Previous Physician's Address, City, State, Zip Code: _____

Phone Number: _____Fax #: _____

Information Requested:
____ Immunization Records Only ___Labs/X-Ray ___All Medical Records
Date of Service: From: _____to_____

Requested information is needed for: [ ] Changing Doctors [ ] Continuing Medical Care [ ] Personal Use
[ ] Other: _____

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/Responsible Party Signature **Patient/Responsible Party Printed Name** **Date**

Relationship to Patient: _____

Revised 08/07/2023