Medical Records Release Authorization for

Arizona Pediatric Clinics, PLLC
809 E Washington Street, Suite 106, Phoenix, AZ 85034
Phone: (602) 340-9455 Fax: (602) 253-5359

Patient's Name: ________________________________ DOB: ______________

Address: ____________________________ City:___________ State: _____ Zip: ______

Daytime Phone#: __________________ Parent/Guardian: _______________________

I hereby authorize the release of the following medical records:

______ Billing Statement

______ Immunization Records

______ Consultation/Progress Notes

______ Other Please specify: ____

Release Medical Records: ____ TO ____ FROM

Arizona Pediatric Clinics
809 E Washington Street, Suite 106, Phoenix, AZ 85034
P: 602-340-9455 F: 602-253-5359

____ TO ____ FROM

(Please print: Physician's name, Address, Phone #, & Fax #)

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Phone #: ____________________ Fax#: ____________________

For the purpose of: ____ Changing PCP ____ Other: ______________________

Medical Records shall include all confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information (as defined in A.R.S. Section 36-661), 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 sixty (60) days after the signed date below. I have given my consent freely, voluntarily, and without coercion. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I also understand that Arizona Pediatric Clinics has up to ten (10) business days to review the medical record and release the copied medical record according to above written request.

Parent/Guardian Signature: ________________________________ Date: ____________