AZKidsDoc Pediatrics

Request for Release of Medical Records TO AZKidsDoc Pediatrics

_____ _____
Name of Child DOB

_____ _____
Name of Child DOB

_____ _____
Name of Child DOB

Release **FROM** _____ Fax _____

Address _____

Release **TO:** AZKidsDoc Pediatrics • 15215 South 48th Street, Suite 110 • Phoenix, AZ 85044 • (480) 783-8964

Method of Delivery: ☐ Mail ☐ Paper (Pick up)
☐ **Fax (480) 783-8967** ☐ Email: kids@azkidsdoc.com

Information Requested: ☐ Clinic Visit Notes ☐ Immunization Records ☐ Lab Reports
☐ X-Ray Reports ☐ Other (Specify): _____

☐ All information regarding care received by patient between the dates of _____ and _____

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the Patient or Parent/Legal Guardian of the Patient named above must initial and date each item. If the item is NOT initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	To
_____	_____	HIV/STD Related Information	_____	_____
_____	_____	Communicable Disease Related Information	_____	_____
_____	_____	Alcohol and Drug Abuse Related Information	_____	_____
_____	_____	Mental Health Diagnosis/Treatment Information	_____	_____
_____	_____	Genetic Testing	_____	_____

I authorize the release of photocopies of the following medical records to the possession or control to AZKidsDoc Pediatrics, the physicians and their employees and/or agents.

I hereby release you, your physician and your employees from any kind of liability for fulfilling the authorization request for release of medical information. The consent will expire 90 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 you in writing to that effect. I understand that any releases which were made prior to my revocation in compliance with this authorization at any time providing I notify you in writing to that effect.

I understand that any releases which were made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

_____

Patient or Parent/Legal Guardian Signature **Date**

_____

Patient or Parent/Legal Guarding Print **Relationship to Patient**