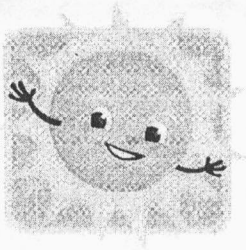

CHANDLER PEDIATRICS **STAT!**

Authorization To Release Medical Records

I hereby authorize the release of photocopies of my medical records in the possession and control of the below name individual/facility, employees and/ or agents for the purpose hereof. Medical records shall include all confidential HIV related information (A.R.S. Section 35-6511); communicable disease related information (A.R.S. Section 36-651); confidential alcohol and drug abuse related information (42CRF Section 2.1 et al); and confidential mental health diagnosis-treatment information unless otherwise directed by me. Description of information to be released (i.e. date of service, test results, immunization records, etc.)

_____ whose date of birth is _____

Name of Patient Birth Date

From:

Office Name: _____

Doctor's Name: _____

Address: _____

Phone: _____ **Fax:** _____

To: CHANDLER PEDIATRICS
1850 W. Frye Rd Suite 102
Chandler, AZ 85224
Phone: 480-782-5575 Fax: 480-782-5576

Please Transfer and/or disclose ALL the following information:

- All medical records, files, charts, reports and other associated health information.
- The following specific Protected Health Information (Check ALL that apply)
  - Medical Records and Charts
  - Immunization records (PLEASE FAX ASAP)
  - X- Rays or diagnostic Results/Lab Results
  - Other (Please Specify)_____

To Be Released For:

_____

Patient Name **Date of Birth**

_____

Printed Name of Person Completing Form **Relationship to Patient**

_____

Signature of Person Completing the Form **Today's Date**