

CHANDLER PEDIATRICS, DR. SUMBUL SHAKOOR

NAME OF PATIENT: _____ DOB _____ / _____ / _____

DATES OF SERVICE: _____

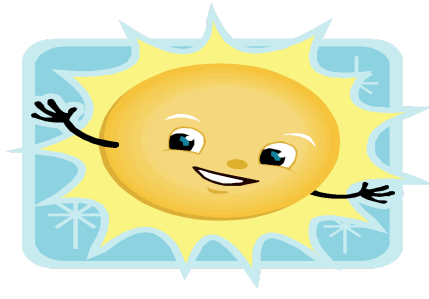
PURPOSE OF RELEASE: _____

PLEASE RELEASE THE FOLLOING INFORMATION:

- ☐ () MEDICAL RECORDS AND CHART NOTES
- ☐ () LABS/XRAY OR DIAGNOSTIC TESTING
- ☐ () HISTORY AND PHYSICAL FORM
- ☐ () SHOT RECORDS
- ☐ () OTHER (PLEASE SPECIFY) _____

I HEARBY AUTHERIZE THE RELEASE OF PHOTOCOPIES OF MY MEDICAL RECORDS IN THE POSSION AND CONTROL OF THE ABOVE 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 SETION 36-651); CONFIDENTIAL ALCHOL AND DRUG ABUSE RELATED INFORMATION (42CFR SECTION 2.1 ET AL); AND CONFRDENTIAL MENTAL HEALTH DIAGNOSIS-TREATMENT UNLESS OTHERWISE DIRECTED BY ME. DESCRIPTION OF INFORMATION TO BE RELEASED (I.E DATE OF SERVICE, TEST RESULTS, IMMUNIZATION RECORDS ETC...)

I HEARBY AUTHORIZE **CHANDLER PEDIATRICS** TO RELEASE ALL OF THE ABOVE RQUESTED INFORMATION RELATIVE TO MY TREATMENT TO:



CHANDLER PEDIATRICS, DR. SUMBUL SHAKOOR

COMPANY, PERSON, FACILITY

ADDRESS

PHONE NUMBER

FAX NUMBER

SIGNATURE OF PATIENT

DATE

SIGNATURE OF AUTHORIZED PERSON

RELATIONSHIP TO PATIENT