North Scottsdale Pediatrics

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:_____ Date of Birth:_____
Patient's Name: _____ Date of Birth:_____
Patient's Name: _____ Date of Birth: _____

_____ **Release records TO North Scottsdale Pediatric Associates from:**

_____ **Release records FROM North Scottsdale Pediatric Associates to:**

_____
Doctor/Medical Group/Parent

_____
Address

_____
City/ State/ Zip Code

_____
Phone/ Fax

Specific authorization for release of information protected By State or Federal Law

I specifically authorize for the release of information relating to:

Substance abuse (alcohol/drug abuse) _____

Mental Health (psychological testing) _____

HIV- related information (AIDS-related testing) _____

Developmental Disabilities _____

Purpose for Release:

___Moving to: _____
___Switching Clinics
Reason: _____
___Insurance change to: _____
___Consultation/Specialist _____
___Legal
___Other (Please Specify):
_____

I authorize you to furnish a copy or summary of medical records on the above named child/children to the above named doctor/medical facility. I release you from all legal responsibility of liability that may be derived from this authorization.

_____ _____
Print Name Date

_____ _____
Parent/ Legal Guardian Relationship to Patient

*****This form expires 6 months from date signed*****

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