

Great Destinations Pediatrics, P.C.
18555 North 79th Avenue • Suite D 101 • Glendale, AZ 85308
Telephone: (623)-878-2800 • Fax: 623-878-9150
www.gdpeds.com

Authorization to Release Medical Information to Great Destinations Pediatrics, PC

Patient Information:

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Address: _____

Phone: _____

I hereby authorize Great Destinations Pediatrics, PC to **RECEIVE** photocopies of medical records concerning the above named patient (s) **FROM:**

<p>Practice/ Company or Person(s) authorized to release records: Name: _____ Address: _____ _____ _____ Phone: _____ Fax: _____ For the purpose of: _____</p>

(Check all that apply)

Records to be included:

____ All Medical Records

____ Copies of Medical Records for the Period:

____/____/____ to ____/____/____
Mo Day Year Mo Day Year

____ Copies of Information described below for the Period:

____/____/____ to ____/____/____
Mo Day Year Mo Day Year

____ Immunization Record

____ Consult Reports

____ Lab, X-Ray

____ Other (Please Specify) _____

____ The following information should **not** be released (Please Specify) _____

In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: Condition relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, AIDS/HIV, and communicable diseases.

This request will remain in effect for 1 year from the date of this request.

I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken.

Signature, Parent/Legal Guardian

Relationship to Patient

Date

06/2010 skf

Records Prepared by _____ Date _____