

Great Destinations Pediatrics, P.C.  
18555 North 79<sup>th</sup> Avenue Suite D101, Glendale, AZ 85308  
Telephone: 623-878-2800 Fax: 623-878-9150

### Authorization for Release of Medical Information

Patient's Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Reason for release of medical information: \_\_\_\_\_

<b>Provider Information</b> (To be sent by)	Name: _____ Address: _____ _____
<b>Request Information</b> (Information to be sent to)	Name: _____ Address: _____ _____

Please release the following information:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Initial Exam  | <input type="checkbox"/> Test Results        | <input type="checkbox"/> Lab Results    |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Progress Notes |

Other (Please Specify): \_\_\_\_\_

This authorization is for release of records for care and treatment for the dates from \_\_\_\_\_ to \_\_\_\_\_ inclusive.

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: Conditions relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, acquired immune deficiency syndrome (aids/HIV), and communicable diseases.

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

Signature, Parent or Legal Guardian \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

Records Prepared by \_\_\_\_\_

Date \_\_\_\_\_