CHILDREN'S MEDICAL GROUP, LTD
6780 W. THUNDERBIRD RD., STE A101
PEORIA, ARIZONA 85381
(602) 843-1991 FAX (602) 843-3224

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Cell Number: _____

I hereby authorize **Children's Medical Group, LTD** to **RECEIVE/ SEND** photocopies of medical records concerning the above named patient TO:

_____
 Name of Practice/ Company authorized to release records

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Fax Number: _____

For the purpose of: _____

ALL Medical records ( )   **Or the following described records only ( )**   **ALL Labs ( )**

_____

_____

I authorize the release of photocopies of my child's medical records and/or X-ray reports in the possession or control of the above practice/ company. As requested, the record is to be <u>sent to Children's Medical Group</u>. FOR THE PURPOSE HEREOF, MEDICAL REDORDS SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION AS DEFINED IN A.R.S. SECTION 36-661, CONFIDENTIAL ALCHOHOL OR DRUG ABUSE RELATED INFORMATION AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ., AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/ TREATMENT INFORMATION. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I UNDERSTAND AND AGREE THAT I MAY BE RESPONSIBLE FOR THE FOLLOWING FEES ASSOCIATIED WITH MY REQUEST: COPYING CHARGES, INCLUDING COST OF SUPPLIES, LABOR, AND POSTAGE RELATED TO THE PORDUCTION OF THIS INFOR-MATION. I AM AWARE THE MINIMUM CHARGE FOR THIS SERVICE IS $10.00.

_____   _____
 SIGNATURE of Patient or Parent/ Legal Guardian   **DATE**

_____   _____
 PRINTED NAME   **RELATIONSHIP**

_____   _____
 IDENTIFICATION (DRIVERS LICENSE, STATE ID, ETC)   **SOCIAL SICURITY NUMBER**