MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, or my child(ren), by releasing a copy of medical records, or a summary or narrative of protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

Previous Office Name/Address/Phone/Fax: _____

_____

Type of information to be released:

____ Complete Records

____ Hospital Records

____ Lab Results

____ Radiology Reports

____ Growth Charts

____ Immunization Record

____ Medication Record

____ Other (specify)

Release protected health information to the following physician/person/facility/entity directly related to medical care:

ABC's Pediatrics PLLC

109 W Main St, Payson, AZ 85541

(928) 474-9399 (PHONE) (928) 474-9831 (FAX)

OFFICE@ABCSPEDS.ORG

The purpose/reason for this release of information is as follows: _____

_____ _____

Parent/Legal Representative Signature Date

Confidentiality Notice: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.