Pediatrics

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: _____

_____

The Information you may release subject to this subject to this signed release form is as follows:

____ Complete Records

____ Growth Charts

____ Hospital Records

____ Immunization Record

____ Lab Results

____ Medication Record

____ Radiology Reports

____ Other (specify)

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

ABC's Pediatrics PLLC

117 E Main St, D100

Payson, AZ 85541

(928) 474-9399 (phone)

(928) 474-9831 (fax)

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

_____ _____

Parent/Legal Representative Name Date