Authorization to Release Medical Records

Payment of $25.00 per child is required prior to releasing records.

Records released to another physician will be free of charge.

Please list all children you wish to have medical records transferred:

Patient Name:_______________________________ DOB:__________________

Patient Name:_______________________________ DOB:__________________

Patient Name:_______________________________ DOB:__________________

Patient Name:_______________________________ DOB:__________________

Please select where you wish to have the records transferred to:

☐ I authorize the medical records to be released to West Valley Pediatrics. Please fax records to the number listed below. If records exceed 20 pages, please mail.

From:______________________________

Address:______________________________

City/St/Zip:______________________________

Ph/Fax:______________/______________

To: 10750 W McDowell Rd Ste G-700
Avondale, AZ 85392
Phone: 623-873-0321
Fax: 623-849-9623

☐ I authorize West Valley Pediatrics to release medical records to:

Physician/Practice:______________________________________

Address:________________________City/State:______________

Phone:______________________Fax:______________________

☐ Records to be released to Parent or Guardian/Self

Information to be released:

☐ Immunization Records ☐ Progress notes from ________ to ________ ☐ ALL medical records

☐ Other (Please specify)____

I authorize the release of photocopies of the above medical records. For the purpose hereof, "Medical records" shall include all confidential HIV-related information, confidential communicable disease-related information, confidential alcohol or drug abuse-related information, and confidential mental health diagnosis/treatment information.

____
Parent/ Guardian Name Printed

____
Relationship to Patient

____
Parent/ Guardian Signature

____
Date