

CAMELBACK PEDIATRICS, P.C.

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Phoenix, Arizona 85018

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SECURE EMAIL:

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REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

DOB: _____

Patient's Name: _____

DOB: _____

Patient's Name: _____

DOB: _____

Patient's Name: _____

DOB: _____

RELEASE TO:

Camelback Pediatrics

3333 E. Camelback Road; Suite 175

Phoenix, AZ 85018

Office: (602) 840-3120

Fax: (602) 840-3237

RELEASE FROM:

Name of Clinic/Provider

Street Address

City, State and Zip Code

Phone

Fax/E-Mail

Reason for requesting records.

____ School registration

____ Parent/Legal guardian's copy

____ Changing provider

____ Insurance change

____ Moving out of geographical area

____ Legal

Records to be included: (Check all that apply)

____ Immunization Record

____ All Medical Records (\$25 fee per child; \$50 per child if coming from storage)

____ Copies of Medical Records for the Period: ____/____/____ to ____/____/____
Mo Day Year Mo Day Year

____ Copies of Information described below ("other") for the Period: ____/____/____ to ____/____/____
Mo Day Year Mo Day Year

____ Other (please specify) _____

____ The following information should not be released (please specify) _____

I authorize the release of medical records as listed above. For the purpose hereof, "medical records" shall include all confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information (as defined in A.R.S. Section 36-661), confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 et seq), and confidential mental health diagnosis/treatment information. This request shall remain in effect for 6 months from the date of this request. I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken.

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, etc.)

Patient or legally authorized individual signature

E-mail address

Date