

# CAMELBACK PEDIATRICS, P.C.

3333 East Camelback Road, Suite 175

Phoenix, Arizona 85018

Phone: (602) 840-3120

Fax: (602) 840-3237

www.camelbackpediatrics.com

SECURE EMAIL: medicalrecords@camelbackpeds.com

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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