

**CHANDLER PEDIATRICS****STAT!****Authorization To Release Medical Records**

I hereby authorize the release of photocopies of my medical records in the possession and control of the below name individual/facility, employees and/ or agents for the purpose hereof. Medical records shall include all confidential HIV related information (A.R.S. Section 35-6511); communicable disease related information (A.R.S. Section 36-651); confidential alcohol and drug abuse related information (42CRF Section 2.1 et al); and confidential mental health diagnosis-treatment information unless otherwise directed by me. Description of information to be released (i.e. date of service, test results, immunization records, etc.)

\_\_\_\_\_ whose date of birth is \_\_\_\_\_  
Name of Patient Birth Date  
From:  
Office Name: \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To: CHANDLER PEDIATRICS  
1850 W. Frye Rd Suite 102  
Chandler, AZ 85224  
Phone: 480-782-5575 Fax: 480-782-5576

**Please Transfer and/or disclose ALL the following information:**

- All medical records, files, charts, reports and other associated health information.
- The following specific Protected Health Information (Check ALL that apply)
  - Medical Records and Charts
  - Immunization records (PLEASE FAX ASAP)
  - X- Rays or diagnostic Results/Lab Results
  - Other (Please Specify) \_\_\_\_\_

**To Be Released For:**

_____	_____
Patient Name	Date of Birth
_____	_____
Printed Name of Person Completing Form	Relationship to Patient
_____	_____
Signature of Person Completing the Form	Today's Date