STAT!

Healing Hearts
Pediatrics, P.L.C.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I herby authorize the release of photocopies of my medical records in the possession and control of the below named 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: Healing Hearts Pediatrics P.L.C.
595 N. Dobson Road, Suite A-18
Chandler, AZ 85224
Phone: (480)821-1400 / Fax: (480)821-2210

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 (PHI) (Check ALL that apply)
  - Medical Records & Charts
  - Immunization Records **(Please fax ASAP!)**
  - X-Rays or Diagnostic Results/Lab Results
  - Other (Please Specify)_____

TO BE RELEASED FOR:

_____
Printed Patient Name **Date of Birth**

_____
Printed Name of Person Completing Form **Relationship to Patient**

_____
Signature of Person Completing Form **Today's Date**