



Scottsdale Children's Group

Medical Records Authorization to Release Protected Health Information:

FROM: Scottsdale Children's Group

ONE CHILD PER FORM: PLEASE USE BLACK INK!

Name of Patient _____ DOB: _____

FROM:

TO: (Please note: by filling out the address & fax# you have given us permission to send requested info to either)

Scottsdale Children's Group

New Physician's office/Parent Name/Day care Name

For the following reason/s (please circle one):

- Insurance changed to _____
- Child over the age of 17 years
- Moving from the area
- Other _____

Address

City State/Zip
Phone# _____

OR

Fax# _____
Please note: we will not call prior to faxing

Check specific records you would like copied and initial:

- Standard Records: _____
Immunizations, problem list & growth chart
- Labs, X-rays
- Immunization Records _____
- Recent Physical/Well Check _____
- All Medical Record (\$25.00 for personal copy) _____
- Please release information which may include Psychiatric counseling, drug or alcohol treatment, and HIV/AIDS related information and confidential communicable disease related information.

Sent to: (Employee use only)

Employee Signature: _____
Date: _____

Provider Approval Signature to copy: _____

We are enclosing the requested medical records. In an effort to be eco-friendly we have copied what we believe is medically pertinent to the patient's on going care, but if you find that you require more information, please contact us at 480-609-8100 and we will be happy to supply the requested information.

This authorization shall be considered invalid after 60 days. I may revoke the authorization at any time by providing Scottsdale Children's Group written notice of revocation. However, I may not revoke the authorization retroactively for information already rendered. I hereby waive all provisions of law and privilege relating to the disclosure hereby authorized.

Name of Parent/Guardian Relationship to Patient Date

****IF PATIENT IS 18 YRS OR OLDER-THEY NEED TO SIGN THIS FORM****