



Scottsdale Children's Group

Medical Records Authorization to Obtain Protected Health Information:

TO: Scottsdale Children's Group

ONE CHILD PER FORM

Name of Patient _____ DOB: _____

FROM:

TO:

 Physician's Name Clinic/Parent address/Day care

 Address

 City State/Zip

 Phone # Fax#

Scottsdale Children's Group
 7555 East Osborn Road, Suite 106
 Scottsdale, Arizona 85251
 (480) 609-8100
 (480) 922-7551 FAX
 7425 East Shea Blvd, Suite 101
 Scottsdale, Arizona 85260
 (480) 609-8100
 (480) 609-8101 FAX

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 _____
- 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: _____

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 MUST SIGN THIS RELEASE FORM****