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:

Scottsdale Children's Group

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

- ○ Insurance changed to ____________
- ○ Child over the age of 17 years
- ○ Moving from the area
- ○ School

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

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

____
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**:

*****Please note: When sending records to another Physician, they only require "standard records".***

- ☐ Immunizations
- ☐ Standard Records (**No Charge**) includes:
  Immunizations, problem list, recent labs & growth chart
- ☐ Labs, x-rays
- ☐ Recent Physical/Well Check
- ☐ All Medical Records ($25.00 - $30.00):includes Rx refills & phone messages
- ☐ 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.

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.

Signature of Parent/Guardian	Print Name of Parent/Guardian	Relation to Patient	Date

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