Surprise Pediatrics ▪ 14239 West Bell Road ▪ Suite 112 ▪ Surprise, AZ 85374
Office (623) 876-9983 Fax (623) 876-9984

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Birthdate: _____

Address: _____

City/State/Zip Code: _____

Home Phone #: _____ Cell Phone#: _____

☐ I authorize Surprise Pediatrics to **release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City State Zip Code

_____
Phone# Fax#
(include Area Code)

OR

☐ I authorize Surprise Pediatrics to **obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City State Zip Code

_____
Phone# Fax#
(include Area Code)

PURPOSE OF THE REQUEST: (check one) ☐ Transfer of care ☐ Insurance change ☐ School Registration ☐ Personal ☐ Other _____

TYPE OF RECORDS REQUESTED: (check one)

☐ Immunization Record only ☐ All medical records

☐ Labs/Xrays _____ ☐ Other: _____
Specific dates, if needed Please describe

☐ ***DO NOT RELEASE THESE RECORDS***: _____

I authorize the release of photocopies of my medical records and/or x-ray reports in the possession or control of the above practice/company (employee and/or agents). FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule**.** I understand this authorization is valid for up to 90-days unless I chose to revoke it in writing prior to the expiration date.

I understand and agree that I may be responsible for the following fees associated with my request: copying charges, including the cost of supplies, labor, and postage related to the production of my information.

_____ _____
Signature of Patient; Parent/Legal Guardian Date

_____ _____
Printed Name Relationship to Patient