Scottsdale Children's Group

Medical Records Authorization to Release Protected Health Information:

FROM: Scottsdale Children's Group

FORM MUST BE COMPLETELY FILLED OUT IN ORDER TO BE PROCESSED

Name of Patient: _____ **DOB:** _____

FROM:

Scottsdale Children's Group
Physician's Name: _____

TO:

_____
Parent's Name / Physician's Office / Child's School

_____
Address

_____
City State/Zip

_____
Phone # Fax #

Please note: By filling out the address & fax # you have given us permission to send requested info to one or other.

Check the following reason/s:

_____ School Purposes

_____ Child is over the age of 17 years

_____ Moving from the area

_____ Other: _____

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.

Employee Signature: _____ **Date:** _____
Logged into Nextgen by: _____
Provider Approval Signature to copy: _____

☐ **Gave copy of record/s to parent in office**

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****