Scottsdale Children's Group

Medical Records Authorization to Obtain Protected Health Information:
TO: Scottsdale Children's Group

ONE CHILD PER FORM

FORM MUST BE COMPLETELY FILLED OUT IN ORDER TO BE PROCESSED

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

FROM:

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

_____
Address

_____
City State/Zip

_____/_____
Phone # Fax#

TO:

Scottsdale Children's Group

☐ **7555 East Osborn Road, Suite 106**
Scottsdale, Arizona 85251
Phone: (480) 609-8100
Fax: (480) 922-7551

☐ **7425 East Shea Blvd, Suite 101**
Scottsdale, Arizona 85260
Phone: (480) 609-8100
Fax: (480) 922-7560

Physician's Name: _____

Please check and initial next to the specific records you would like copied:

☐ _____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.

Employee Signature: _____ **Date:** _____

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 MUST SIGN THIS RELEASE FORM****