Scottsdale Children's Group
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

____ I authorize Scottsdale Children's Group **to release** the following information to: _____
(Name of the Person or Facility)

_____
Address City State Zip

_____
Telephone Fax

_____ Immunizations only _____ Labs / X – Rays only _____ Recent Physical / Well Check

_____ Standard Records (No Charge) includes: Immunizations, Problem List, Recent Labs and Growth Chart

_____All medical records (Charge of $25 - $30) includes: Rx refills and phone messages

I do not want the following information disclosed (as defined by applicable state and federal laws):

_____ Alcohol/Drug Abuse _____ HIV Test Results _____ Mental Health/Developmental Disabilities

____ I authorize Scottsdale Children's Group **to request** my medical records from _____
(Name of Provider or Facility)

_____
Address City State Zip

_____
Telephone Fax

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____
Signature of Parent/Guardian or Signature of Patient if 18 years of age or older | Print Name | Relationship to Patient | DATE

This Medical Records Release Authorization will expire in one (1) year from the date signed.

Documents given in office _____ Completed by _____

Provider Approval Signature to Copy _____ Logged into Nextgen by _____