SCOTTSDALE CHILDREN'S GROUP
A Division of Arbor Medical Partners

Susan K. Burke, MD, FAAP Anne T. Garrett, MD, FAAP Arturo Gonzalez, MD, FAAP Nandini Kanagal, MD, FAAP
Katherine S. Lichtsinn, MD, FAAP Satish Namjoshi, MD, FAAP

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 _____

7425 E. SHEA BLVD., SUITE 101, SCOTTSDALE, AZ 85260 PH (480) 609-8100 FAX (480) 922-7551
7555 E. OSBORN RD., SUITE 106, SCOTTSDALE, AZ 85251 PH (480) 609-8100 FAX (480) 922-7551
www.scottsdalechildrensgroup.com