655 S. Dobson RD., Suite. B-218, Chandler, AZ 85224
Telephone: (480) 722-1180 Fax: (480) 722-1187

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST THAT:

Previous Physician/or Practice:_____

Telephone:_____ Fax_____

Last Name of Patient:_____First Name_____

Patient's Birth Date: _____ Telephone (____)_____

RELEASE A COPY OF MY CHILD'S MEDICAL RECORD TO: Crossroads Pediatrics

INFORMATION REQUESTED (X): ( ) Records from last 12 months and most current specialist reports, labs and immunization records ( ) Entire Record: immunization record, growth chart, office visit notes, hospitalization, mental health, consultation reports, labs and x-ray reports.

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON:

( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes ( ) Personal Interest
( ) Other:_____

The authorization must be signed and dated and may be revoked by notifying Crossroads Pediatrics in writing at any time except to the extent action has been taken prior to revocation . This consent will expire 90 days after the date below or sooner by my choice, in which case this consent will expire on this date or event _____.Such expiration date or event has not occurred . I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and / or blood borne infectious disease, which are subject to federal and / or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature _____Date_____
Patient, Parent or Legally Authorized Representative's relationship to the patient: _____