Great Destinations Pediatrics, PC
7757 W. Deer Valley Rd• Suite 275• Peoria, AZ 85382
Telephone: (623)-878-2800 • Fax: 623-878-9150
www.gdpeds.com

Authorization to Release Medical Information to Great Destinations Pediatrics, PC

Patient Information:
Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Address: _____

Phone: _____

I hereby authorize Great Destinations Pediatrics, PC to **RECEIVE** photocopies of medical records concerning the above named patient(s) **FROM:**

Practice/ Company or Person(s) authorized to release records:
Name: _____
Address: _____
_____
_____
Phone: _____ **Fax:** _____
For the purpose of:

(Check all that apply)
Records to be included:

_____ All Medical Records
_____ Copies of Medical Records for the Period: ____/___/___ to ___/___/____
Mo Day Year Mo Day Year
_____ Copies of Information described below for the Period: ___/___/___ to ___/___/_____
Mo Day Year Mo Day Year
_____ Immunization Record
_____ Consult Reports
_____ Lab, X-Ray
_____ Other (Please Specify) _____
_____ The following information should **not** be released (Please Specify) _____

In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: Condition relating to drug and/or alcohol abuse, condition related to psychiatric/psychological treatment, AIDS/HIV, and communicable diseases.

This request will remain in effect for 1 year from the date of this request.

I understand that I may revoke this authorization at any time in writing except to the extent that action based on this authorization has already been taken.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc…)