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…)

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