Great Destinations Pediatrics, P.C.
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

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

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Address: _____

Phone: _____

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

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

(Check all that apply)
Records to be included:

_____ All Medical Records _____ Immunization Record
_____ 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)
_____ Consult Reports _____ Lab, X-Ray
_____ Other (Please Specify) _____
_____ The following information should **not** be released (Please Specify) _____

We want to thank you for entrusting our practice with providing medical care for your child/children. We appreciate feedback and would like to know your reason for requesting records.

_____ Moving out of Geographical Area _____ Changing of Physician
_____ Insurance Change _____ Parent/Legal Guardian's Copy
_____ Legal _____ Customer Service

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. PLEASE ALLOW 14 BUSINESS DAYS FOR ALL MEDICAL RECORD REQUESTS

_____ _____
Patient or legally authorized individual signature Date

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