



P. 480-385-5055
F. 480-385-5054

PENDLETON
PEDIATRICS
RECORD RELEASE FORM

RELEASE FROM:

Name/Clinic

Address

City State Zip

PLEASE MAIL RECORDS TO:

PENDLETON PEDIATRICS
1445 W. Chandler Blvd., Bldg B
Chandler, AZ 85224

Please release records on the following patient(s):

- 1. _____ Date of Birth: _____
- 2. _____ Date of Birth: _____
- 3. _____ Date of Birth: _____
- 4. _____ Date of Birth: _____

The health information to be used / disclosed includes: (check all that apply)

- All health information including but not limited to AIDS/HIV and other communicable disease information, behavioral health care/ psychiatric care, alcohol and or drug abuse treatment, if any, unless specifically accepted: _____
- Health information relating to the following condition: _____
- Health information for the date(s): _____
- Immunization record

This authorization ends: (check only one)

- on this date _____
- 6 months from the date of authorization (this is default if no box checked)

I understand I do not have to sign this authorization in order to get health care benefits. I understand that I may revoke this authorization in writing at any time except to the extent that Pendleton Pediatrics has acted in reliance upon this authorization. Once the office discloses health information the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

Signature of parent/legal guardian: _____ **Date:** _____

Relationship to Patient: _____