Noah's Ark Pediatrics

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

17560 N. 75th Ave., Suite 400
Glendale, AZ 85308
P: (623) 931-5001 F: (623) 979-8268

20 PG'S OR MORE, PLEASE DO NOT FAX! MAIL RECORDS, THX!

1. Regarding Patient COMPLETE IN FULL

Name-Last, First, MI		
Street Address		Telephone #
City	State	Zip Code
Insurance ID #	Birthdate	

2. Records Released From			**3. Records Released To**		
Name (i.e. Health Facility, Physician...)			Name (i.e. Insurance Co. Lawyer, Physician, Self...)		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
Phone #			Phone #		

4. INFORMATION TO BE RELEASED: (Check all applicable categories)

___ Complete Copy of All Records ___ Immunization Records ___ Allergy Records
___ Telephone/Verbal communication ___ ER Visits ___ X-ray Reports/Films
___ Lab Reports ___ Urgent Care ___ Physical Exams/EPSDT
___ Clinic records pertaining to outpatient treatment of: (Specify approximate date(s) or condition)_____
___ Other (Specify) _____

FOR THE FOLLOWING DATES: _____

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable Categories)

___ Further Medical Care ___ Payment of insurance clain ___ Application for Insurance
___ Legal Investigation ___ Personal ___ School Disability
___ Academics ___ Other:_____

6. I authorize release of my medical records in accordance with the specification listed above. I understand that I have the right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

7. Signature of patient: _____Date_____
(If signed by person other than patient, state relationship and authority to do so.)

8. NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.