# 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...) Noah's Ark Pediatrics | Name (i.e. Insurance Co. Lawyer, Physician, Self...) |
| Street Address 17560 N. 75th Avenue, Suite 400 | Street Address |
| City Glendale State AZ Zip Code 85308 | City State Zip Code |
| Phone # 623-931-5001 | Phone # |

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

_X_ Complete Copy of All Records
___ Telephone/Verbal communication
___ Lab Reports
___ Immunization Records
___ ER Visits
___ Urgent Care
___ Allergy Records
___ X-ray Reports/Films
___ 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)**

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

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.