The Pediatric Endocrine & Diabetes Clinic, PC

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Voice: (602) 277-1117 * Fax: (602) 626-3577

CONSENT TO RELEASE MEDICAL INFORMATION

Obtain Records From: _____

Address: _____

_____

Phone: _____ Fax: _____

Send Records To: The Pediatric Endocrine & Diabetes Clinic, PC ☐ Mail ☐ Fax

Patient's Name: _____ Birth Date: _____

Parent or Guardian: _____

Purpose of Request:
- ☐ Continuation of medical care
- ☐ Parent request
- ☐ Other: _____

I, undersigned, do hereby authorize and request The Pediatric Endocrine & Diabetes Clinic, PC through its authorized employees or representative agents to furnish or receive from the above named physician , office or agency the following information regarding my child: THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661) CONFIDENTIAL ALCOHOL OR DRUG-ABUSE RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH-DIAGNOSIS AND/OR TREATMENT INFORMATION.

Please mark the appropriate boxes of information to be requested:

- ☐ Endocrine Physician Notes/ Letters:
- ☐ All Medical Records ☐ Outpatient ☐ Inpatient
- ☐ Growth Chart
- ☐ Lab Reports
- ☐ X-Ray Reports
- ☐ Other:

I understand that this information is strictly confidential as protected under the Federal Confidentiality Regulation. I understand that this authorization will expire in one year unless a written request for an extension is received. Furthermore, I understand that I may at any time through written notice, amend or revoke this authorization. I agree that a copy of this authorization shall be as valid as the original. In furtherance of this authorization, I do hereby wave all provisions of law and privileges relating to the disclosure hereby authorized.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

_____

RELATIONSHIP TO CHILD