



Mahmoud B. Kabbani, M.D.
7010 East Chauncey Lane,
Suite 210
Phoenix, AZ 85054

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 waive all provisions of law and privileges relating to the disclosure hereby authorized.

SIGNATURE OF PARENT/GUARDIAN

DATE

RELATIONSHIP TO CHILD