Moon Valley Pediatrics

Moon Valley Corporate Center
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Phone: 602.298.6930 Fax: 602.298.6918

AUTHORIZATION TO RELEASE RECORDS

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/____
mm dd yyyy

Address: _____

RECORDS TO BE RELEASED BY

Medical Facility / Physician: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Release: _____

RECORDS TO BE RECEIVED BY

Medical Facility / Physician: _____

Address: _____

I authorize the release of photocopies of the following medical records in the possession or control of Shiraz H. Ladha M.D., P.C.; A.K.A Moon Valley Pediatrics; it's employees or agents, FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE A CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

This consent will expire sixty (60) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Moon Valley Pediatrics in written form. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ ____/____/____
Patient Signature Date

_____ _____
Parent / Legally Authorized Representative Relationship to Patient

_____ ____/____/____
Notarized (if not signed in office) Date