Medical Records Release (One patient per form please)

Patient Name:_____ DOB:_____

Address:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

I hereby voluntarily authorize the disclosure/release of all medical records:

Circle One: **To** or **From**

Valley of the Sun Pediatrics, P.C

21681 North 77th Avenue, Suite 1410
Peoria, AZ 85382
623-362-1818 (phone)
623-362-8095 (fax)

Check purpose of release:

____ Transfer to new physician (Complete records including Immunization records)
Immunizations records only
____ Other (describe) _____

_____

Circle One: **To** or **From**

Physician, Facility or Hospital: _____

Facility Address: _____

Phone: _____

Fax: _____

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. This authorization may be revoked in writing at any time. The disclosed information may be subject to redisclosure by the recipient. This authorization expires six months from the date signed.

Parent or Guardian Name (print):_____Relationship to Patient:_____

Parent or Guardian Signature:_____Date:_____

NOTE: PLEASE PROVIDE THIS DOCUMENT TO THE FACILITY OR PHYSICIAN THAT CURRENTLY HAS YOUR RECORDS