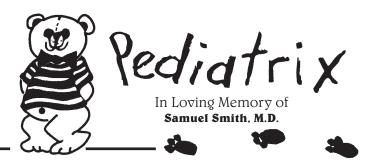
Harold Magalnick, M.D. Nicholas Argyros, M.D. Jack Herchold, M.D. Ronald Serbin, M.D. David Kleiner, M.D. Luis Arroyo, M.D. Subir K. Mitra, M.D. Arun J. Nemivant, M.D.



Yvonne M. Funcke, M.D. Michael B. Magalnick, D.O. Gina D. Montion, M.D. Cathy Kelley, P.A.-C. Lisa Drummond, PNP Cherilyn Jacobson, P.A.-C. Amy Miceli, P.A.-C.



"We Care For Kids"

AUTHORIZATION TO RELEASE RECORDS

Patient Na	me		
Date of Birth		HIPAA ID#	
Address_			
City		State 2	Zip Code
Phone (Day)		(Home)	
•	ase of photocopies of medical re	cords concerning the	above-named patient: TO:
(Name of company to release records)		(Name of company or person(s) to receive records)	
Address		Address	
City	State, Zip Code	City	State, Zip Code
Fax		Fax	
employees and / or agents HIV-RELATED INFORMATI RELATED INFORMATION	S. FOR THE PURPOSE HEREOF, ON (AS DEFINED IN A.R.S. SEC (AS DEFINED IN A.R.S. SEC-TIO (AS DEFINED IN 42 CFR SECTIC	"MEDICAL RECORD: TION 36-661), CONFI N 36-661), CONFIDE	ssession or control of Pediatrix, its S" SHALL INCLUDE ALL CONFIDENTIAL IDENTIAL COMMUNICABLE DISEASE- NTIAL ALCOHOL OR DRUG ABUSE- O CONFIDENTIAL MENTAL HEALTH PLEASE SELECT ONE: (A)- Mail
Medical Records (check o	ne)		B- Fax
☐ All medical reco			©- Disc \$30 D- Pick-up/Hand carry
Li The following d	escribed records ONLY (specify t	ypes and dates)	
Parent / Legally Author	ized Representative	Date	
Relationship to Patient			
Signature of Pediatrix Representative		Date	