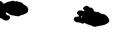
Harold Magalnick, M.D. Habes Sawalqah, M.D. Nicholas Argyros, M.D. Jack Herchold, M.D. Ronald Serbin, M.D. David Kleiner, M.D. Luis Arroyo, M.D. Subir K. Mitra, M.D. Arun J. Nemiyant, M.D.



Marianne Borch-Christensen, M.D. Yvonne M. Funcke, M.D. Gina D. Montion, M.D. Cathy Kelley, P.A.-C. Sharon Harkins, CPNP Lisa Drummond, PNP Julie Bellah, PNP



"We Care For Kids"

## **AUTHORIZATION TO RELEASE RECORDS**

	Patient Name			
			¥	
	Date of Birth HIPAA ID#			
	Address			
	City	State	Zip Code	-
	Phone (Day) (Home)			
I hereby auth above-named		_ to send / release photoc	opies of medical records co	oncerning the
	(Name of company or person(s) to receive records)			
	Address	City	State, Zip Code	
INCLUDE ALI CONFIDENTI TION 36-661)	L CONFIDENTIAL HIV-RI AL COMMUNICABLE DI , CONFIDENTIAL ALCO FION 2.1 ET SEQ.), AND	ELATED INFORMATION (A ISEASE-RELATED INFORM HOL OR DRUG ABUSE-RE	EREOF, "MEDICAL RECOR S DEFINED IN A.R.S. SECT MATION (AS DEFINED IN A. ELATED INFORMATION (AS HEALTH DIAGNOSIS / TRE	TION 36-661), R.S. SEC- S DEFINED IN
Medical Reco	ords (check one)			
	medical records (or) e following described re	cords ONLY (specify types	and dates)	
			,	
	Parent / Legally Authorized R	epresentative	Date	
	Relationship to Patient		_	
	Records prepared and transr	nitted by:	_	
	Signature of Pediatrix Repres	sentative	 Date	-

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