**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.**

# Pediatrix

In Loving Memory of
**Samuel Smith, 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 Name _____

Date of Birth _____ HIPAA ID# _____

Address _____

City _____ State _____ Zip Code _____

Phone (Day) _____ (Home) _____

I hereby authorize the release of photocopies of medical records concerning the above-named patient:

| **FROM:** | **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 |

I authorize the release of photocopies of the following medical records in the possession or control of Pediatrix, its employees and / or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SEC-TION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS / TREATMENT INFORMATION.

PLEASE SELECT ONE:
Ⓐ- Mail
Ⓑ- Fax
Ⓒ- Disc $30
Ⓓ- Pick-up/Hand carry

Medical Records (check one)

☐ All medical records
(or)
☐ The following described records ONLY (specify types and dates) _____

_____

_____ _____
Parent / Legally Authorized Representative Date

_____
Relationship to Patient

_____ _____
Signature of Pediatrix Representative Date