



Ronald S. Fischler M.D. F.A.A.
Vivian G. Ziltzer M.D. F.A.A.P
Jeffrey E. Siegel M.D. F.A.A.P
Catharine S. Cesal M.D. F.A.A.P.

Jennifer R. Caplan M.D. F.A.A.P
Lisa R. Engel M.D. F.A.A.P
Matthew Barcellona M.D.
Laura Honch M.D.

Jennifer Gerlach M.D.
Becky Purinton C.P.N.P
Jennifer Brodie C.P.N.P

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name

Date of Birth

_____ Release records TO North Scottsdale Pediatric Associates from:

_____ Release records FROM North Scottsdale Pediatric Associates to:

Doctor/ Medical Group/ Parent

Address

City/ State/ Zip Code

Phone/ Fax

I authorize you to furnish a copy or summary of medical records on the above named child/children to the above named doctor/medical facility. I release you from all legal responsibility of liability that may be derived from this authorization.

Parent/ Legal Guardian

Date

Reason For Request: _____