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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 OR MEDICAL GROUP

ADDRESS

CITY/STATE/ZIP CODE

PHONE/FAX

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

Signed _____
Parent/Legal Guardian

Date

REASON FOR REQUEST: _____

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