NORTH SCOTTSDALE PEDIATRICS
A Division of Arbor Medical Partners

Matthew Barcellona, M.D. F.A.A.
Vivian G. Ziltzer M.D. F.A.A.P.
Jeffrey E. Siegel M.D. F.A.A.P
Catharine Cesal, M.D. F.A.A.P.
Jennifer Caplan, M.D. F.A.A.P.
Lisa R. Engel, M.D. F.A.A.P.
Katie Conover, M.D, F.A.A.P
Sarah Wiersma, M.D. F.A.A.P
Jennifer Gerlach, M.D. F.A.A.P.
Sherry Pottgen, M.D. F.A.A.P.
Adrienne Kurland, M.D. F.A.A.P.
Colin Petranu, M.D. F.A.A.P.
Jennifer Cropp, M.D. F.A.A.P.
Rebecca Smith, M.D. F.A.A.P
Tyler Dirvonas, M.D. F.A.A.P
Karen Eynon, C.N.P.N
Lisa Boucek, M.D. F.A.A.P
Joy Ball, M.D. F.A.A.P
Michele Singer M.D. F.A.A.P
Alexandra Tsontakis, M.D. F.A.A.P

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:_____ **Date of Birth:**_____
Patient's Name: _____ **Date of Birth:**_____
Patient's Name: _____**Date of Birth:** _____

_____ **Release records TO North Scottsdale Pediatric Associates from:**

_____ **Release records FROM North Scottsdale Pediatric Associates to:**

_____
Doctor/Medical Facility/Parent

_____
Address

_____
City/ State/ Zip Code

_____
Phone/ Fax

I authorize the following types of information to be released:

___ Complete Records
___ Imaging Results
___ Lab Results
___ Immunizations
___ Office/Clinical Notes
___ Growth Charts
___ Medications
___ Other: _____

Specific authorization for release of information protected by State or Federal Law. I specifically authorize for the release of information relating to:

___Mental Health ___ Substance Abuse ___ HIV related
___ Developmental Disability Records

Purpose for Release:

___ Moving out of State
___ Switching Clinics
___ Legal
___ Education
___ Other: _____

Receive records via
___ Email
_____
___ Fax
___ Mailed to the above address

I authorize you to furnish a copy or summary of medical records on the listed child/children to the listed Doctor/Medical Facility/Person. I release you from all legal responsibility of liability that may be derived from this authorization.

_____ _____
Print name Relationship to patient

_____ _____
Parent/Legal Guardian/Patient (if 18 years or older) Signature Date

This form expires 1 year from date signed

IRONWOOD • 9827 N. 95th Street, Suite 105• Scottsdale, AZ 85258
DEER VALLEY • 21807 N. Scottsdale Road • Scottsdale, AZ 85255
Phone (480) 860-8488 • Fax (480) 860-8498
Email: medicalrecords@nspeds.com