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Sarah Wiersma, M.D.
Tyler Dirvonas, M.D.
Karen Eynon, C.N.P.N
Lisa Boucek, M.D.

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 Group/Parent

____
Address

____
City/ State/ Zip Code

____
Phone/ Fax

Specific authorization for release of information protected By State or Federal Law

I specifically authorize for the release of information relating to:

Substance abuse (alcohol/drug abuse) _____

Mental Health (psychological testing) _____

HIV- related information (AIDS-related testing) _____

Developmental Disabilities _____

Purpose for Release:

___Moving to: _____________
___Switching Clinics
Reason: ______________
___Insurance change to: ______
___Consultation/Specialist ______
___Legal
___Other (Please Specify):
____

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.

____ __________________________
Print name Relationship to Patient

____ __________________________
Parent/Legal Guardian Signature Date

*****This form expires 6 months from date signed*****

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