Mesquite
PEDIATRICS

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Full Name: _____

Address: _____

Phone Number: _____

This Authorizes: Mesquite Pediatrics
5983 E Grant Rd, Suite 105
Tucson, AZ 85712
Phone 520-648-5437 Fax 520-648-5438

To Release Information to: _____
(new provider name)

_____
(new provider address)

_____ _____
(phone number) (fax number)

Please initial next to any of the following categories of records that you would like to have transferred:

___ Mental condition and/or treatment including psychotherapy notes

___ Drug or alcohol abuse and/or treatment

___ HIV, AIDS, or AIDS-related complex condition and/or treatment

I authorize the release of all my medical records including those noted above.

This authorization releases Mesquite Pediatrics and any staff, employees, and agents of any responsibility for information contained in such records released in case of loss or theft from my person, or distress of any type caused to me or other. Mesquite Pediatrics will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

_____ _____
Signature of Parent/Guardian, or patient if over 18 Date

If over 30 pages, fax immunizations and mail other records