Dale W. Guthrie, MD FAAP Randy H. Leavitt, MD FAAP Gary G. Auxier, MD FAAP M. Melani Jaskowiak, RN CPNP
Lafe J. Carroll, DO FAAP Deborah D. Howard, RN MS PNP Tim Jacks, DO FAAP Sam Shumway, PA

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

20 pg's or MORE, PLEASE DO NOT FAX! MAIL RECORDS, THX!

List Multiple Patients on One Form

Patient Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

Parent's Name Phone Number

Check Only One:

ALL information must be provided or records will not be sent/requested.

☐ I would like to release records TO Gilbert Pediatrics FROM:

_____
Doctor or Medical Center Name

_____
Full Address

_____

_____
Phone Number AND/OR Fax Number

OR

☐ I would like to release records FROM Gilbert Pediatrics TO:

_____
Doctor or Medical Center or Parent's Name

_____
Full Address

_____

_____
Phone Number AND/OR Fax Number

Reason for Request:_____

In accordance with Federal Regulations 42 CFR PART 2, I hereby consent to the release of photocopies of records pertaining to the following:

[ ] **All Records $10 fee per child**
$15 when mailed

[ ] Immunizations, problem list, medication list, and growth chart only

☐ [ ] Illness/Hospitalizations

☐ [ ] Labs

This consent will expire 60 days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Gilbert Pediatrics, Inc. in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. **There will be a charge for additional copies requested as well as an additional charge for mailing records.**

Signed _____ Date _____
Parent/Legal Guardian

4540 E. Baseline Rd. Suite 108 Mesa, Arizona 85206 (480) 892-3880 Fax (480) 545-4551