Gilbert Pediatrics

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

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

_____	_____
Doctor or Medical Center Name	Doctor or Medical Center or Parent's Name
_____	_____
Full Address	Full Address
_____	_____
_____	_____
Phone Number AND/OR Fax Number	Phone Number AND/OR Fax Number

Reason for Request:_____

In accordance with Federal Regulations 42 CFR PART § 2.33 and 42 CFR § 164.506, 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