Banner Pediatric Specialists

Pediatric Surgery

Medical Records Release Form

Patient Name:___________________________________ Date of Birth:________________

Patient/Guardian Authorization

You may use or disclose the following health care information:

❒ All my health information including, but not limited to, AIDS/HIV and other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted: _______________________________________

❒ Other ____

You may disclose this health information to:

Name:________________________________

Address:_______________________________

Phone:________________________________ Fax:_____________________________

Do you want us to ❒ fax or ❒ mail your child's medical records?

This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

____ __________________________________

Patient or legally authorized individual signature | Date

____ __________________________________

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian)

Mesa | 1432 S. Dobson Road, Suite #301, Mesa, AZ 85202; Phone 480-412-9400; Fax 480-412-9401
Glendale | 5757 W. Thunderbird Road, Suite #W-406, Glendale, AZ 85306; Phone 602-865-4011; Fax 480-865-6100

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