

**PHOENIX PEDIATRICS LTD.**

6702 North 19th Avenue 4735 East Union Hills Drive  
 Phoenix, AZ 85015-1101 Phoenix, AZ 85050  
 602-242-5121 602-971-5121  
 602-242-6945 Fax Fax 602-971-3122  
 Website: phoenixpediatrics.com

Gerald H. Golner, MD FAAP  
 David Hirsch MD, MS FAAP  
 Thomas D. Barela, MD PhD FAAP  
 Pamela S. Murphy, MD FAAP  
 Melissa F. Redleaf, MD FAAP  
 Bradley F. Golner, MD FAAP  
 Sakina Raza, MD FAAP  
 Anthony R. Nagorka, MD FAAP

Kevin Berger, MD FAAP  
 Victoria S. Simpson, RN MS CPNP  
 Karen S. Eynon, RN MSN CPNP  
 Jeanne Gibian, RN MSN CPNP  
 Jennifer Valentine, RN MSN CPNP

**AUTHORIZATION  
TO RELEASE  
RECORDS**

PATIENT NAME		DATE OF BIRTH
ADDRESS		
WORK PHONE	HOME PHONE	SOCIAL SECURITY #

(check one)  I hereby authorize Phoenix Pediatrics LTD. to send / release photocopies of medical records concerning the above named patient to:  
 I hereby authorize the provider listed below to send / release photocopies of medical records concerning the above named patient.

PHYSICIAN OR PERSON(S) AUTHORIZED TO RECEIVE / RELEASE RECORDS
ADDRESS
FOR PURPOSE OF

I authorize the release of photocopies of the following medical records in the possession or control of Phoenix Pediatrics LTD., it's employees or agents. FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS / TREATMENT INFORMATION.

**Medical Records** (check one)  All medical records of the past two (2) years of treatment.  
 The following described records *only* (specify types and dates) \_\_\_\_\_

This consent will expire sixty (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 Phoenix Pediatrics LTD. 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.

_____	_____
Patient signature	Date
_____	_____
Parent / Legally authorized Representative	Relationship to Patient

Records prepared and transmitted by: \_\_\_\_\_ Date \_\_\_\_\_