

RECORDS RELEASE AUTHORIZATION

TO _____
DOCTOR OR HOSPITAL

ADDRESS

THEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:
PARADISE PEDIATRICS, P.C. 4626 E. Shea, Suite C-100, Phoenix, AZ 85028 (602) 996-0190, Fax (602) 996-5516

JOSEPH CEIMO, M.D., F.A.A.P. VINAY KWATRA, D.O., F.A.C.O.P.
W. KEVIN QUINN, M.D., F.A.A.P. MICHAEL STAMPS, M.D., F.A.A.P. SARA VELAZQUEZ KERTZ, D.O., F.A.A.P., F.A.C.O.P.

I request the release of photocopies of the following medical records in your possession or control. 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 36-881), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/ TREATMENT INFORMATION

NAME _____ DOB _____ DATE _____

ADDRESS _____

SIGNATURE _____ WITNESS _____
(If relative, state relationship)

Rev 12/5/07