Palo Verde Pediatrics, PLLC

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize:

____ Palo Verde Pediatrics
120 S. Val Vista Drive
Gilbert, AZ 85296-1370
Ph: (480)733-6500 Fax: (480)621-4916

____ _____
_____
_____

To furnish a copy of the medical records and/or immunization records, including HIV testing, of the patient listed below to:

____ _____
_____
_____

____ Palo Verde Pediatrics
120 S. Val Vista Drive
Gilbert, AZ 85296-1370
Ph: (480)733-6500 Fax: (480)621-4916

I hereby release you, your physicians and your employees from any liability for following this authorization and request. This authorization will expire at the end of 90 (ninety) days from the date on this form.

_____ Patient Name

_____ Name of Parent/Guardian

_____ Patient Date of Birth

_____ Signature Parent/Guardian Last 4 SSN

_____ Patient Address

_____ City, State, ZIP

_____ Reason for Records

_____ Today's Date

THERE IS A FEE OF $20 IF YOU NEED MEDICAL RECORDS FOR YOUR PERSONAL FILES. NO CHARGE TO TRANSFER RECORDS TO A NEW PHYSICIAN