Richard Reznick MD, Sergio Sotelo MD, Scott Cannon MD
Phone: (480) 778-1732 Fax: (480) 778-1709
www.papagopeds.com
Unsecure Email: records@papagopeds.com

CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____

RELEASE MEDICAL INFORMATION FROM:

_____
(Name of practice/physician) (Address)

_____
(Phone Number) (Fax Number)

Information to be released:
_____ All health information
_____ All health information related to the following condition: _____
_____ All health information for the following dates: From: ____ / ____ / ____ To: ____ / ____ / ____
_____ Other information (please be specific): _____

RELEASE MEDICAL INFORMATION TO:

Papago Buttes Pediatric Center, P.C.
8573 E San Alberto, Suite E-100
Scottsdale, AZ 85015
Phone: (480) 778-1732 Fax: (480) 778-1709

Send medical records via: _____ Fax (if 25 pages or less) _____ Mail (discs are accepted)

By signing this consent form, I authorize the practice/physician listed above to release protected health information regarding my child/children (listed above) in the form specifically noted. I authorize this information to be released to Papago Buttes Pediatric Center P.C. I understand you will only be able to release protected health information generated by your office.

_____
Patient/Authorized Adult Signature Date

_____
Printed Name Relationship (if signing on behalf of the patient)