Michael Arbel, M.D. F.A.A.P.
Farha Khan, M.D. F.A.A.P.
Jennifer Valentine, C.P.N.P.
Catherine Tretiakova, C.P.N.P.

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:____________________________________Date of Birth:____________________

______ Release records **TO** Southwest Pediatrics from:

______ Release records **FROM** Southwest Pediatrics to:

Office/Doctor/Parent ________________________________________________

Address ______________________________________________________

City/State/Zip Code _________________________________________________

Phone ______________________________________________________________

Fax ____________________________________________________________

Specific authorization for release of information protected by State or Federal Law
I specifically authorize for the release of information relating to:

Substance abuse (alcohol/drug abuse) _______
Mental Health (psychological testing) _________
HIV related information (AIDS related testing) ________
Developmental Disabilities _______

Purpose for Release: ___________________________________________

I authorize you to furnish a copy or summary of medical records on the above-named child to the above-named doctor/medical facility. I release you from all legal responsibility of liability that may derived from this authorization.

______________________________________ ________________________________
Print Name Relationship to Patient

______________________________________ ________________________________
Parent/Legal Guardian Signature Date

***This form expires 6 months from date signed***

**Southwest Pediatrics**
9150 W Indian School Rd. Suite 127, Phoenix, AZ 85037
Phone: 623-931-3028 Fax: 623-931-3029