SCOTTSDALE PEDIATRIC CENTER, P.C.

Fellows of the American Academy of Pediatrics
RUSELLE WALLACE, M.D.
WENDY KAYE, M.D.
TRACI L. HURLEY, M.D.

AUTHORIZATION TO RELEASE HEALTH RECORDS

Please fax records to: (480) 860-4306

or mail to 10752 N. 89th Place, STE C-126 Scottsdale, AZ 85260

spcfrontoffice@coxbusiness.net

NO DISCS PLEASE

Patient Information

Name: _____

Date of Birth: _____

Address: _____

_____

Phone Number: _____

Please check ONE of the following:

_____ **Obtain medical records from prior physician***

*Please include the last two years

Well Exams | Immunization Records | Growth Chart | Labs, Radiology, Diag. | Medication List

Prior Physician Name: _____

Address: _____

_____

Phone: _____ FAX: _____

_____ **Release medical records from Scottsdale Pediatric Center to:**

Physician Name: _____

Address: _____

_____

Phone: _____ FAX: _____

I authorize the release of all the health information of the above patient that is in the possession or control of the provider, it's employees and/or agents.

I understand information in my/my child's health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse.

My signature authorizes such release as indicated above. I have given my consent freely, voluntarily and without concern. I understand a photocopy of this authorization is acceptable in lieu of the original.

Signature: _____ Date: _____

Printed Name: _____