



happy kids *pediatrics*

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825 W. Southern Ste 106
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Phone (602) 243-3429
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Medical Release Authorization

Previous Medical Provider and or Facility Name: _____

Address _____

Phone _____

I authorize you to release photocopies of confidential medical records to possession or control of Happy Kids pediatrics P.C., it's employees or agents. FOR THE PURPOSE 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 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFE SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS AND TREATMENT INFORMATION.

Patients full name: _____ Date of Birth: _____

This authorization may include items protected by code of federal regulations, 42 CFR, part 2, and other provisions set forth in A.R.S. Sections 36-661. This request is in compliance with the health insurance portability accountability act of 1996 (HIPAA).

The information requested is to be used for the purpose of: _____

I specifically request the following type of information be released: _____

This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance of this consent prior to revocation. In any event, this authorization expires 12 months after the date of signature.

Parent/Legal guardian _____ Date _____

Relationship to Patient _____

Signature of Witness _____