CATALINA PEDIATRICS — Fax 520-323-3460
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name _____ Account # _____

Former Name (if any) _____ Social Security # _____

Daytime Telephone _____ Birthdate _____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____
To release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physician/Organization	Street Address	City/State/Zip
Catalina Pediatrics	3085 N. Swan Rd	Tucson, Az 85712
Phone: 520-323-3099	Fax: 520-323-3460	

PURPOSE OR NEED FOR THIS INFORMATION (Please check a box)

❑ Moving ❑ Specialist Appt. ❑ Dissatisfaction ❑ Change of Insurance Plans
❑ Other (specify) _____

TYPE OF INFORMATION TO BE RELEASED (No information will be released unless a box is checked)

General Release	DATE OF TREATMENT
❑ Medical Records/Excluding Protected Records (this will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated)	From _____ To _____
❑ Other Records (specify) _____	From _____ To _____

Information Protected by State/Federal Law

❑ Drug Abuse Diagnosis/Treatment	From _____ To _____
❑ Alcoholism Diagnosis/Treatment	From _____ To _____
❑ Mental Health Diagnosis/Treatment (may include treatment of pain management and center women's health or psychiatry)	From _____ To _____
❑ Sexually Transmitted Disease Diagnosis/Treatment or Counseling (includes AIDS/HIV)	From _____ To _____
❑ Communicable Disease and Related Information	From _____ To _____
❑ Genetic Testing Information	From _____ To _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

_____ _____
Signature of Patient OR Legal Representative Please Print Name of signing party

_____
Date Signed

Patient Requesting Medical Records Copy
$10.00 for the first page, each additional page $.20
Total _____ # of Pages _____

NOTE: If this request is made by mail, this office requires the request be notarized by a State Notary Public.