Print Form

Banner Pediatric Specialists

Pediatric Surgery

Medical Records Release Form

Patient Name:_____ Date of Birth:_____

Patient/Guardian Authorization

You may use or disclose the following health care information:

☐ All my health information including, but not limited to, AIDS/HIV and other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted: _____

☐ Other _____

You may disclose this health information to:

Name:_____

Address:_____

Phone:_____ Fax:_____

Do you want us to ☐ fax or ☐ mail your child's medical records?

This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian)

Mesa 1432 S. Dobson Road, Suite #301, Mesa, AZ 85202; Phone 480-412-9400; Fax 480-412-9401
Glendale 5757 W. Thunderbird Road, Suite #W-406, Glendale, AZ 85306; Phone 602-865-4011; Fax 480-865-6100

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