OLD PUEBLO PEDIATRICS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

IT IS THE PATIENT'S RESPONSIBILITY TO PROVIDE COMPLETE ADDRESS INFORMATION. INCOMPLETE REQUESTS WILL NOT BE PROCESSED!!!!

Please Print
PATIENT NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION (RECORDS)

FROM:

_____

_____

_____

TO:
Old Pueblo Pediatrics, PLLC
John R. Bean, MD
Zebulon Delp, MD
Samantha L. Mansfield, MD
Acacia Packer, DO
3043 W. Ina Rd., Suite 115, Tucson, AZ 85741
(520) 797-7070 Fax: (520) 797-7077

I hereby request and authorize the release of the following information:

☐ All Medical Records Available

☐ Medical Records for the period of _____ through _____

☐ Other (specify): _____

_____

PURPOSE OF DISCLOSURE (*Required*): ☐ School ☐ Insurance Change ☐ Insurance Claim

☐ Changing Doctor ☐ Moving ☐ Other (specify): _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically one year from the date on which it is signed. Any further disclosure of medical record information by the recipient(s) is not authorized without the specific written consent of the person to who it pertains.

_____ Date: _____
Signature of Patient

*If patient is a minor and information is to be released regarding mental health, drug or alcohol abuse, both the patient and parent must sign.

_____
Signature of Parent/Guardian

_____
Relationship to Patient