JJ Pediatrics .com
Phone: 480-677-4545
Fax: 480-677-4356
21321 East Ocotillo Road, Suite 110
Queen Creek, Arizona 85142
Brian DeWitt, DO

Authorization for Disclosure Of Health Information

I hereby authorize the release of photocopies of my medical records in the possession and control of the below named individual/facility, employees, and/or agents for the purpose hereof. Medical records shall include all confidential HIV related information (A.R.S. Section 35-6511); communicable disease related information (A.R.S. Section 36-651); confidential alcohol and drug abuse related information (42CRF Section 2.1 et al); and confidential mental health diagnosis-treatment information unless otherwise directed by me. This authorization is valid for 1 year after the signature date. I understand that there is no cost to me for requesting to send medical records to another medical facility. I understand that if I want a copy of medical records for personal use, there will be a fee associated with this request and I agree to be responsible for that charge.

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

_____**Please release records TO JJ Pediatrics from:**
_____**Please release records FROM JJ Pediatrics to:**

Name/ Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please send the following:

- ☐ Medical Summary, last well visit, growth charts, immunization records, labs and imaging, most recent specialist reports, and any ADHD/ behavioral health records.
- ☐ Newborn Hospital Records: H&P, Discharge Summary, Labs, Imaging or specialist reports
- ☐ Other (specify) _____

_____ _____

Name of Person Completing Form **Relationship to Patient**

_____ _____

Signature **Date**