AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Phoenix/Avondale/Laveen
*****PLEASE MAIL ALL CORRESPONDENCE TO THE PHOENIX LOCATION*****
4700 N 51st Ave, Suite 4 \ Phoenix, AZ 85031 \ P: 623-846-7575 \ **F: 623-846-3778**

Patient's Full Name:____DOB:____________________
Home address:____
City:___________________ State:_____ Zip: _______________ Phone Number: ___________________

Pick Option #1 or #2

#1 Send my MVP Kids Care Information TO:
Name: ____
Address: ____
Fax number: ______________________ Phone number:____________________________

#2 Get my medical information FROM:

Name: ____
Address: ____
Fax number: ______________________ Phone number:____________________________

This authorization releases MVP Kids Care, its staff, employees and/or agents, of any responsibility for information contained in such record release in case of loss or theft from my person, or distress of any type caused to me or others. MVP Kids Care will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

I am requesting (pick A or B)

A. Medical records for the past 2 years (including immunization records), **OR**

B. Other:_______________________________________

I understand this medical information may include sensitive information. I authorize release of:

____ All HIV related information and communicable disease related information (ARS 36-661)
____ Information related to psychiatric/psychological treatment
____ Information related to physical abuse, sexual abuse or molestation
____ Information related to drug and/or alcohol abuse

I understand I may revoke this consent at any time. This consent will automatically expire one (1) year following the date signed, unless I request differently.

Your signature:_______________________________________Date signed:______________________

Printed Name: _______________________________________Relationship to patient:______________