

COTTONWOOD PEDIATRICS RECORD RELEASE FORM

PLEASE NOTE:

- 1. Please complete the records release form on the next page. You must complete a separate form for each child.**
- 2. Fee for records sent to you is \$10 per copy per child. Please pay by check or money order (to Cottonwood Pediatrics) and mail payment with a completed release form for each child to: Cottonwood Pediatrics, PO Box 1510, Higley, AZ 85236).**
- 3. There is no fee for records you request be sent to another healthcare provider. However, once we have transferred records to your new provider, that new provider is responsible for future transfer of your Cottonwood records to any future providers your child has. A records release to another provider can be faxed (to (844) 540-3637) or mailed to us.**

COTTONWOOD PEDIATRICS, PLC

PO Box 1510, HIGLEY, AZ 85236

FAX: (844) 540-3637

Christopher Hickie, M.D.

AUTHORIZATION TO RELEASE RECORDS FROM COTTONWOOD PEDIATRICS

Patient's Name: _____ DOB: _____

Address: _____ Phone #: _____

I hereby authorize to **send** photocopies of medical records concerning the above named patient **from:**

Cottonwood Pediatrics, PLC
PO Box 1510
Higley, AZ 85236

For the purposes of: **Continuity of care, as Cottonwood closed on 4/8/2016**

I authorize the release of photocopies of the following medical records to:

Name: _____

Address: _____

City, State, ZIP: _____

including employees and/or agents. For the purposes hereof, "Medical Records" shall include all confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential alcohol or drug-abuse related information (as defined in 42CFR section 2-1 ET SEQ) and confidential mental health diagnosis/treatment information.

MEDICAL RECORDS (check one or more)

All medical records

The following described records only (please specify types and dates): _____

This consent will expire within sixty (60) days after the signed date below. I have given my consent freely, voluntarily, and without coercion. I may revoke this authorization at any time providing I notify Cottonwood Pediatrics, PLC in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Parent Signature

RECORDS PREPARED AND TRANSMITTED BY (*to be completed by Cottonwood staff*):

Signature of Representative

Date