COTTONWOOD PEDIATRICS, PLC

PO BOX 1510, HIGLEY, AZ 85236
PHONE (520) 965-5541 FAX (480) 248-6035

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: _____

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 section2-1 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:

_____ _____
Signature of Representative Date