Children's Medical Center of Tucson

Medical Record Release

Patient Name: ______________________________ DOB: ______________________________

Address: ______________________________ Phone #: ______________________________

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Obtain Records From:

____

Address: ______________________________

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Phone: ______________________________

Send Records To:

____

Address: ______________________________

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Phone: ______________________________

This authorization releases Children's Medical Center of Tucson and any of its staff and employees of any responsibility for information contained in such records. Children's Medical Center of Tucson will not be held liable for any misuse of misunderstand of the information contained here in as a result of this release.

Photocopies of information to be released: (Please check what is authorized to be released)

☐ Medical Records of the past two (2) years of treatment

☐ Other (specify) ______________________________

I authorize the release of records pertaining to:

☐ All HIV-related information and communicable disease related information

☐ Conditions related to Psychiatric / Psychological treatment

In accordance with federal regulations 42 CPR part 2, I hereby consent to the release of records pertaining to treatment and diagnosis of:

☐ Conditions related to drug and/or alcohol treatment

The information is needed for the following purposes:

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I understand I may revoke this consent at any time and that upon fulfillment of the above-stated purposes. The consent will automatically expire one (1) year following the date of my signature without express revocation.

______________________________ Signature of parent or legal guardian

______________________________ Date:

***There is no charge when records are sent to a physician for continuing care. A copying fee of $25 is charged when records are released to a parent or other non-physician recipient. ***