

Mesquite Pediatrics
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PARENT/GUARDIAN'S FULL NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

PATIENT NAME: _____ DOB: _____

THIS AUTHORIZES:

Mesquite Pediatrics
2350 N. Kibler, Ste. 1
Tucson, AZ 85712

TO RELEASE INFORMATION TO:

THIS AUTHORIZATION RELEASES MESQUITE PEDIATRICS AND ANY STAFF, EMPLOYEES AND AGENTS OF ANY RESPONSIBILITY FOR INFORMATION CONTAINED IN SUCH RECORDS RELEASED IN CASE OF LOSS OR THEFT FROM MY PERSON, OR DISTRESS ANY TYPE CAUSED TO ME OR OTHER. MESQUITE PEDIATRICS WILL NOT BE HELD LIABLE FOR ANY MISUSE OR MISUNDERSTANDING OF THE INFORMATION CONTAINED HEREIN AS A RESULT OF THIS RELEASE.

PLEASE INITIAL NEXT TO ANY OF THE FOLLOWING CATEGORIES OF RECORDS THAT YOU WOULD **NOT** LIKE TO HAVE TRANSFERRED:

- _____ Mental condition and/or treatment including psychotherapy notes
_____ Drug or alcohol abuse and/or treatment
_____ HIV or AIDS or AIDS related complex condition and/or treatment

I AUTHORIZE THE RELEASE OF ALL MY MEDICAL RECORDS, INCLUDING ALL HIV AND COMMUNICABLE DISEASE RELATED INFORMATION, MENTAL CONDITION(S) AND/OR TREATMENT INCLUDING PSYCHOTHERAPY NOTES, DRUG OR ALCOHOL ABUSE AND/OR TREATMENT, EXCEPT AS NOTED ABOVE.

PATIENT SIGNATURE, PARENT OR GUARDIAN

DATE SIGNED