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: _________________________

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TO RELEASE INFORMATION TO: **Mesquite Pediatrics**
2350 N. Kibler, Ste. 1
Tucson, AZ 85712

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________ Mental condition and/or treatment including psychotherapy notes

________ Drug or ahcohol 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 ALCOLHOL ABUSE AND/OR TREATMENT, EXCEPT AS NOTED ABOVE.

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PATIENT SIGNATURE, PARENT OR GUARDIAN DATE SIGNED