

Children's Oasis Pediatrics

1425 w. Elliot Road, Suite 204 • Gilbert, Arizona 85233
Phone: (480) 792-1012 • Fax: (480) 792-1013

To Children's Oasis Pediatrics from previous PCP

Authorization to Release Healthcare Information

If records are more than ten pages, please mail.

Patient's Name (Last, First): _____

Patient's Date of Birth (Month/Day/Year): _____ / _____ / _____

I request and authorize:

Name of Practice/Facility: _____

Name of Doctor/Administrator: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____

to release healthcare information of the patient named above to Children's Oasis Pediatrics.

This request and authorization applies to (check all that apply):

All health information including, but not limited to, AIDS/HIV and other communicable disease information, behavioral healthcare/psychiatric care, alcohol and/or drug abuse treatment, if any, unless specifically excepted:

Health information relating to the following treatment, condition, or dates:

Health information for the date(s): _____

Immunization record only

This authorization ends:

On this date: _____ / _____ / _____

6 months from the date of authorization (default if neither box is checked)

Signature: _____ Date: _____ / _____ / _____

Name (Print): _____

Relationship to Patient: _____ Phone: (_____) - _____ - _____