MORNING STAR PEDIATRICS
3507 S. MERCY ROAD, SUITE 103
GILBERT, AZ 85297
TELEPHONE: (480) 355-8530 FAX: (480) 591-3115

Authorization To Obtain Medical Records/Information

Patient Name:_____
Address: _____
Home Phone: _____ Work Phone: _____
Social Security Number: _____ Date of Birth: _____

I authorize Dana Rodriguez, PhD, PNP-BC to *obtain* medical records / information *from*:

_____
Name: Phone Fax

_____
Address City State Zip Code

Please release the following information from my medical record:

_____Complete Record _____Laboratory Report(s) _____Radiology Report(s) _____Other_____

_____ _____ _____ _____
Date(s) of service Date(s) of service Date(s) of service Date(s) of service

Send to: Dana Rodriguez, PhD, PNP-BC
3507 S. Mercy Road Suite 103
Gilbert, AZ 85297
Ph: 480-355-8530 Fax: 480-591-3115

The purpose of this request is for: (*please check ALL that apply*):

_____Further Medical Care _____Insurance _____Disability/Worker's Compensation

_____Personal Care _____Legal _____Other: _____

Expiration of Authorization: I understand that this authorization shall expire, without my express revocation, six (6) months from the date written below (sixty [60] days for drug/alcohol abuse treatment records).
Right of Revocation: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do this in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Disclosure of Information: I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected.
Marketing Purposes: I understand this information will in no way be used for marketing purposes.

_____
Legally Authorized Representative / Patient **Signature** Date

_____
Legally Authorized Representative / Patient **Printed Name** Relationship to Patient Date

_____
Signature of Witness Information Prepared & Released By Date

In the case of a patient who is physically unable to sign this authorization, he/she should place and "X" on the signature line and have his/her assent witnessed.