



From: Dr. _____

To: Jyoti Patel, MD FAAP
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RELEASE OF MEDICAL RECORDS

Please release entire record.

I hereby consent to the release of records pertaining to treatment/diagnosis of the following.

- Confidential Alcohol in Drug Abuse-Related information (as defined in 42 CFR Section 2.1 ET SEQ)
- Confidential HIV-Related Information (as defined in A.R.S. Section 36-611)
- Confidential Mental Health Diagnosis/Treatment information.
- Confidential Communicable Disease-Related information (as defined as A.R.S. Section 36-611)

I authorize the facsimile transmission of the above records.

Yes _____ No _____

I understand that this authorization shall expire, without my express revocation, six months from the Date written below (60 days for drug/alcohol abuse). I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Printed Name _____ Date of Birth _____

Signature _____ Date _____

Parent/Legally authorized Representative _____

Signature of Witness _____ Date _____