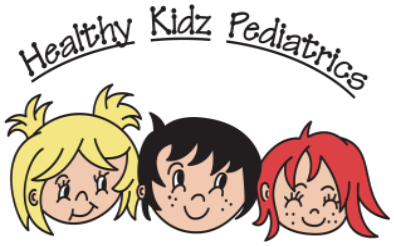

MEDICAL RECORD RELEASE AUTHORIZATION

Previous Medical Provider or Facility Name: _____

Address: _____

_____

Phone: _____

From: HEALTHY KIDZ PEDIATRICS
215 SOUTH POWER RD STE #106
MESA, AZ 85206 Phone (214-0051) Fax (480) 214-0055

I authorize you to release photocopies of confidential medical records to possession or control of Healthy Kidz Pediatrics it's employee or agents. FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661) CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFE SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS AND TREATMENT INFORAMTION

_____ _____
Patient's Full Name Date of Birth

This authorization may include items protected by Code of Federal Regulations, 42 CFR Part 2, and other provisions set forth in A.R.S. Sections 36-661, they may include items related to communicable diseases (as defined in A.R.S. Section 36-661). This request is in compliance with the health insurance portability and accountability act of 1996 (HIPAA).

The information requested is to be used for the purpose of: _____
_____

I specifically request the following type of information be released: _____
_____

This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance of this consent prior to revocation. In any event, this authorization expires twelve (12) months from the date of signature.

Parent/Legal Guardian: _____ Date: _____
Relationship to Patient: _____
Signature of Witness: _____