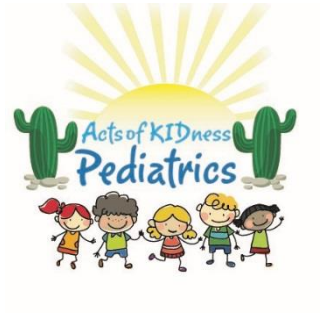
PLEASE SEND EACH PATIENT'S RECORDS SEPERATELY

Acts of KIDness Pediatrics, PLLC
861 N Higley Rd Suite B101
Gilbert, AZ 85234
Phone: 480-664-6400
Fax: 480-500-5779



Dr Alison Wilcock MD, FAAP
Dr Sonja Stevenson MD, FAAP
Dr Marguerite Keane MD, FAAP
Dr Sandra Romero MD, FAAP

Authorization for Release of Information

Patient Name(s) _____ Date of Birth_____

_____ _____

_____ _____

_____ _____

□ Release records TO Acts of KIDness Pediatrics, PLLC from:

□ Release records FROM Acts of KIDness Pediatrics, PLLC to:

Doctor or Medical Practice _____

Phone Number _____

Fax Number _____

Type of Information to be released:

□ All Records
□ Discharge Summary
□ Immunizations/Growth Charts
□ Specialty Notes
□ Lab Results
□ Imaging Results
□ Illness/Hospitalizations

This authorization will automatically expire one year from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation. I understand that Acts of KIDness Pediatrics may not condition my treatment on whether I sign this authorization form. I authorize Acts of KIDness Pediatric, PLLC to use and disclose the protected health information specified above.

Parent or Guardian Signature _____ Date _____