



Advance Pediatrics PLLC

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Release of Medical Records

I hereby authorize:

**Advance Pediatrics, PLLC
9836W Yearling Rd. F- 1300, Peoria, AZ 85383**

**Advance Pediatrics, PLLC
8232 W Cactus Rd. Ste #124 Peoria, AZ 85381**

To release all checked patient pertinent medical records for the following
Patient.

Patient Name: _____

DOB: _____

☐ Evaluations. ☐ Growth Charts.

☐ Immunizations. ☐ Radiology Results

☐ Lab Results. ☐ Consult Notes.

I understand this may include information relating to STI (Sexually Transmitted Infections)
including AIDS, HIV Infection, Psychiatric Care, and/or treatment for substance abuse including
alcohol and or drug addiction.

Please send medical records to:

Physician or Facility

Address

City, State & Zip Code

I understand that I have a right to receive a copy of this authorization.

Parent or Legal Guardian Signature

Date

Relationship to Patient

Office Staff Initials & Date