Sonoran Medical Centers
19875 N. 51st Avenue
Glendale, AZ 85308
Phone: (623) 581-8998
Fax: (623) 581-6461

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____Date of Birth: _____
Phone:_____ Address: _____
City:_____State:_____Zip Code: _____

I hereby authorize
Name of facility:_____
Address:_____City:_____
State:_____ Zip Code:_____Phone:_____Fax:_____
to disclose the following Protected Health Information pertaining to the patient listed above to Sonoran Medical Centers.

Options below must be completed in order to release records.

For the Following Purpose:
☐ New Primary Care Physician
☐ Personal Records
☐ Consultation with Specialist
☐ Insurance Company
☐ FMLA/Disability
☐ Other (Specify) _____
☐ Other (Specify) _____

Information to be Released:
☐ All Records
☐ Records from _____ to_____
☐ Office Note
☐ Radiology Report ☐ Lab result
☐ Other
☐ Billing Statements
☐ FMLA/Disability Forms (please mark above if records to be released also)

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS'), human immunodeficiency virus ('HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.
I understand that Sonoran Medical Centers will not condition treatment on whether I sign this Authorization.
I understand that I have the right to revoke this authorization at any time except to the extent that the above-named facility has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mailing address listed above. I understand the revocation will not apply to information that has already been released in response to this Authorization.
I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives this information.

I understand that this authorization will expire one (1) year from date of signing unless specified below.

Desired Expiration Date _____

_____ _____
Signature **Date**

_____ _____
Print Name **Relationship to Patient (if not patient)**