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 Sonoran Medical Centers to disclose the following Protected Health Information pertaining to the patient listed above to (complete address must be listed to process this request):
Name of facility: ____
Address:____City:________________________
State:_________ Zip Code:________________Phone:___________________Fax:_____________________

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

☐ Other (Specify) _______________________

Information to be Released:

☐ All Records
☐ Records from ___________ to___________
☐ Office Note
☐ Radiology Report
☐ Lab result
☐ Billing Statements
☐ FMLA forms and records

A fee of $70.00 will be charged for records released to patient or insurance company. This charge is waived if records are forwarded to another physician's office or releasing records directly to patient if requesting fewer than 10 pages (for example, a lab or radiology report). ***Not applicable to multiple requests in order to receive entire chart.***

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 Sonoran Medical Centers 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)**