



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:

- checkbox New Primary Care Physician
checkbox Personal Records
checkbox Consultation with Specialist
checkbox Insurance Company
checkbox FMLA/Disability
checkbox Other (Specify) \_\_\_\_\_
checkbox Other (Specify) \_\_\_\_\_

Information to be Released:

- checkbox All Records
checkbox Records from \_\_\_\_\_ to \_\_\_\_\_
checkbox Office Note
checkbox Radiology Report checkbox Lab result
checkbox Other
checkbox Billing Statements
checkbox 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)