SUNRISE MEDICAL CENTER
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date:_____

PATIENT NAME:_____ D.O.B._____
Address:_____
_____
Phone No:_____ Fax No:_____

I authorize _____
Physician Name
_____
Address City, State Zip Code
Phone Number _____ Fax Number_____

To release information **to:**

Sunrise Medical Center
13634 N. 93rd Avenue, Suite 100
Peoria, AZ 85381
Phone: 623-933-0301 Fax: 623-933-0224

PLEASE DO NOT SEND RECORDS ON A CD

RELEASE ONLY:

Last 3 office notes
Recent Labs
Last EKG
Last EMG
All Pulmonary Function Tests
Last Colonoscopy
Last Echo/Dopplers
Pertinent Xrays/Imaging
All Sleep Studies

I understand that medical information may include if applicable: Alcohol and/or drug abuse and/or mental health treatment information protected under the regulation in Title 42 of Code of Federal Regulations Part II. Information about Human Immunodeficiency Virus – HIV, acquired immunodeficiency syndrome – AIDS, and AIDS related complex – ARC, as defined by Department of Public Health rules (1989 Public act 174), third party information. I understand that I may revoke this authorization at anytime by notifying Sunrise Medical Center in writing, otherwise, it will remain in effect for a period of 12 months from the date signed. This authorization pertains to fulfillment of the above stated purpose(s). Covered entity will not condition treatment, payment, enrollment or eligibility. I understand that information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA's privacy rule protections.

I have read the above, and acknowledge that I am familiar with and fully understand the terms and condition of this authorization.

_____ _____
Patient, Parent or Guardian Signature Date