PEORIA/SUN CITY OFFICE
13634 N. 93rd Ave., Suite 100
Peoria, AZ 85381
623-933-0301 • FAX: 623-933-0224

GLENDALE OFFICE
5750 W. Thunderbird Rd., Bldg. G Ste. 780
Glendale, AZ 85306
602-314-4220 • FAX: 602-314-5631

SUNRISE MEDICAL MANAGEMENT

SURPRISE OFFICE
18731 N. Reems Rd., Bldg F #680
Surprise, AZ 85374
623-975-0592 • FAX: 623-933-0224

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

Phone Number: _____

I authorize _____ to release information contained in my medical records to:

☐ Self – Mail requested records to the mailing address above.

Physician Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

☐ Sunrise Medical Center: __ Peoria Location __ Glendale Location __ Surprise Location

Purpose of this release: __ Personal Use __ Temporary Transfer __ Permanent Transfer

__ Continuing Care __ Other (please explain): _____

Specific Information to be disclosed:
****PLEASE DO NOT SEND RECORDS ON A CD****

☐ Last 3 office notes only
☐ Recent Labs
☐ Lask EKG
☐ Last NCV
☐ All Pulmonary Function Tests
☐ Other: _____

☐ All Records
☐ Last Colonoscopy
☐ Last Echo/Dopplers
☐ Pertinent X-rays/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 released 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 any time 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 in 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 conditions of this authorization.

_____ _____

Patient, Parent, or Guardian Signature Date