Authorization to Release Medical Records

Sun Lakes Family Physicians, L.L.C., 10450 E. Riggs Rd., Ste 114, Sun Lakes, AZ 85248
Office: 480-505-2450 Fax: 480-505-2464

Patient_____Date_____Time_____am/pm

Date of Birth_____Phone Number_____

Address_____City_____State/Zip_____

I, the undersigned, authorize Sun Lakes Family Physicians to provide the following persons or entities with a copy of any and all records, documents, reports, clinical abstracts, histories and charts, of any kind and description, related to care or services furnished to the patient named above:
FOR THE PURPOSE HEREOF, "MEDICAL RECORDS "SHALL INCLUDE ALL:

Confidential HIV-Related information (as defined in A.R.S. Section 36-661)
Confidential Communicable disease-related information (as defined in A.R.S. Section 36-661)
Confidential Alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 ET SEQ)
Confidential Mental Health diagnosis/treatment information
Confidential Genetic Testing information (as defined in A.R.S. Section 12-2801)

***Complete address, phone (required) and fax number of where records are being sent. (New doctor, specialist, insurance company, yourself etc.)**

☐ Personal Use ☐ Specialist/ New Physician ☐ Insurance Co./Attorney

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Phone_____Fax_____

Please include the following records:

☐ Most Recent Lab ☐ Most Recent Radiology ☐ All Records

☐ Notes Pertinent to Specialist Visit ☐ Other_____

The records copied for this release will be available for three (3) months from the date of signing. I may revoke this authorization at any time by providing written notice of revocation. I acknowledge, however, that I may not revoke the authorization for retroactively for information already released.

X_____ _____
Patient Date

X_____ _____
Parent/Guardian/POA Relationship to Patient

A physician has approved release of:

Labs Xrays Progress Notes Reports All Records

Other_____Physician Initials_____

1/24/18