AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Phone: _____

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Purpose of records transfer:

- ☐ Continuity of care
- ☐ Moving
- ☐ New physician
- ☐ Personal record tracking
- ☐ Other :_____

Requesting Records From: _____

_____

Phone: _____ Fax: _____

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Send Records to: **East Valley Center for Pulmonary and Sleep Disorders**
2121 E Pecos Rd Ste. 3
Chandler, Arizona 85248
Phone: (480) 398-2480 Fax: (480) 398-2483

Please release all medical records unless specific dates, diagnoses, or other items listed:

_____

_____

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I authorize the requested records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information relating to mental health and/or alcohol or drug use to be forwarded to the above name and address.

I further authorize these medical records to be faxed if necessary.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.

_____ _____
Patient Signature Date

_____
Witness