East Valley
Center for Pulmonary & Sleep Disorders

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Phone: _____ Address: _____ City: _____ State: _____

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Purpose of records transfer: _____

Requesting Records From: East Valley Center for Pulmonary & Sleep Disorders

- ☐ 2121 E Pecos Rd Ste 3 • Chandler, AZ 85225
  Office (480) 398-2480 Fax: (480) 398-2483
- ☐ 3155 E Southern Ave Ste 203 • Mesa, AZ 85204
  Office (480) 325-8173 Fax: (480) 325-8179
- ☐ 37100 N. Gantzel Rd Ste 113 • San Tan Valley, AZ 85140
  Office (480) 398-2480 Fax: (480) 398-2483

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Send Records to: _____

_____

Phone: _____ Fax: _____

(PLEASE ALLOW 7-10 WORKING DAYS)

Please release **all medical records** unless specific dates, diagnosis, 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