Seyed A. Javadpoor, M.D.
Lina A. Anthony, M.D.
Alhassan Badahman, M.D.

Dashant S. Kavathia, M.D.
Arturo "Happy" Castro, D.O.
Salman Sheikh, M.D.
Sankalp Choudhri, M.D.

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient's Name: ____ Date of Birth: ____________________

Phone: __________________ Address: _______________________________ City: __________ State: ______

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Purpose of records transfer: ____

Requesting Records From: ____

____

Phone: _______________________________ Fax: ____________________________

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

____

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Send Records to: 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

****

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