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gastroenterology | endoscopy

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AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS

Today's Date: _____/_____/_____

Patient Name: _____
(First) (MI) (Last)

Date of BIrth: _____/_____/_____ SG Physician (circle): Dr. Lowe Dr. Khosla Dr. Davis Dr. Sethi

Phone: _____Email: _____

Release Medical Records From:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____Fax: _____

Release Medical Records to:

Name: Sonoran Gastroenterology

Address: 950 N McQueen Rd Ste 100

City, State, Zip: Chandler, AZ 85225

Phone: 480-542-7000 Fax: 480-542-7500

Please release the following: (Check all that apply)

Complete Medical Record ▢ Lab Reports ▢ Billing Records ▢ Clinical Records Related To:

_____

_____

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization. Unless otherwise revoked, this authorization will expire one (1) year from the signing date.

I authorize Sonoran Gastroenterology to release or obtain medical records as specified above.

_____ _____/_____/_____
Signature Date

_____
Printed Name