Sunny View Medical Center

Tax ID # 71-0972832

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MEDICAL RECORDS RELEASE AUTHORIZATION

I _____ hereby authorize
(Please Print)

Office/Physician/Hospital Name: _____

Address: _____

Telephone: _____Fax:_____

to release any information including the diagnosis and records of any treatment or examination rendered to me during the period

From _____ / _____ / _____ Through_____ / _____ / _____

To my physician at:

Sunny View Medical Center, PLLC
4400 N 32nd Street, Suite 110
Phoenix, Arizona 85018

I acknowledge that such records and/or information may contain information related to mental health and/or drug and alcohol treatment. I also acknowledge that such records and/or other information may contain references to the following: Syphilis, Gonorrhea, Chlamydia, HIV/AIDS or any other sexually transmitted diseases and acknowledge that these are reportable communicable diseases under the law of the State of Arizona. I hereby waive all provisions of law and privilege relating to the disclosures hereby authorized.

Date of Birth: _____ Gender: _____

Patient Name: _____
(Please Print)

Signature: _____ Date: _____
(Patient or Guardian)

Witness: _____ Date: _____