Sunny View Medical Center

Tax ID # 71-0972832

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MEDICAL RECORDS RELEASE AUTHORIZATION

I acknowledge that a medical records fee will be assessed for records released to an

Individual, Attorney, or Life Insurance Company

I _____ **hereby authorize my physician at**
(Please Print)

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

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

From _____ / _____ / _____ Through _____ / _____ / _____

to the following

Physician/Hospital/Other Name: _____

Address: _____

Telephone: _____Fax:_____

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: _____