

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I authorize \_\_\_\_\_ to  
release my medical records and/or information to

**Arizona Sun Family Medicine, P.C.**

**Rakesh Patel, M.D.**

**633 E. Ray Road, Suite 101**

**Gilbert, Arizona, 85296**

**P#: (480) 222-1171**

**F#: (480) 222-4684**

**BY SIGNING THIS FORM, I AUTHORIZE THE RELEASE OF MY ENTIRE  
MEDICAL RECORD**

HIV/AIDS: I consent to the release of any positive or negative test results or AIDS or  
HIV infection, antibodies to HIV/AIDS, or infection with any other causative agent of  
AIDS with the rest of my medical record. Initial: \_\_\_\_\_ Date: \_\_\_\_\_

The medical records or medical information are requested for the purpose of continuing  
my medical care and treatment.

I understand that I have a right to revoke this authorization at any time. I understand that  
if I revoke this authorization, I must do so in writing and present any written revocation  
to the medical record department. I understand that the revocation will not apply to any  
information that has already been released in response to this authorization. I understand  
that the revocation will not apply to my insurance company when the law provides my  
insurer with the right to contest a claim under my policy.

Unless I specify differently, this authorization will expire six months from the date signed  
below.

I understand that once the above information is disclosed, it may be re-disclosed by the  
recipient and that the information may not be protected by federal privacy laws or  
regulations.

I understand that the use or disclosure of the information identified above is voluntary; I  
need not sign this form to ensure healthcare treatment.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

If signed by legal representative, relationship to the patient: \_\_\_\_\_