

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
(480) 222-1171
(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 redisclosed 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: _____

Signature of Witness Date