SONORAN
VEIN AND ENDOVASCULAR

Authorization for Release of Medical Records

9192 W. Union Hills Drive, Peoria, AZ 85382
P: 602-374-4101 Fax: 602-441-0522

Date: _____

Patient's Name: _____ **DOB:** ____/____/____

I, _____, request that copies or summaries, as required by state law, of the medical records pertaining to my healthcare be released as written below.

Records To Be Sent or Requested:
Practice or Physician's Name: _____
Address: _____
Phone: _____ **Fax:** _____
Type of Records Requesting: _____
Approximate Date of Records Requesting: _____

I hereby authorize and provide my written consent for this release for the above facility to provide a transfer of my records/medical information.

X_____ _____
Signature of Patient **Date**
X_____ _____
Signature of Witness **Date**

If Records To Be Mailed or Picked Up ONLY, Please Fill Out the Following:

☐ **MAIL:**
Street (Including Suite/APT # if Applicable):
_____
City, State, ZIP
_____

☐ **PATIENT TO PICK UP RECORDS: MUST ALLOW 48 HOURS**
THERE IS A FEE FOR RECORDS FOR PICK UP: Staff will provide cost per patient request