Authorization to Obtain or Release Medical Records

SONORAN SKY SURGICAL

Patient's Name: _____ Other Name(s): _____

Address (Street, City, State, Zip Code): _____

Date of Birth: _____ Telephone Number: _____

We may need to obtain prior medical records to facilitate your care and schedule procedures.

_____ I authorize your office to get records from the following (other physicians, hospitals, imaging centers, etc where you have been treated for the condition you are being seen for):

Your Initials

Name, Address, Phone, Fax

1. _____

2. _____

_____ I authorize your office to send my records to the following (other physicians, myself, attorneys, etc):

Your Initials

Name, Address, Phone, Fax

1. _____

2. _____

Information to be disclosed covering the period from _____ to _____:

___ Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records

___ Copy of all health records to **exclude** HIV testing/results, mental health and/or alcohol or drug abuse records

Specific records:

- ☐ Operative report
- ☐ History and physical
- ☐ Laboratory test results
- ☐ Pathology report
- ☐ Consultation reports
- ☐ X-ray reports/images
- ☐ Discharge summary
- ☐ Progress notes
- ☐ Emergency room record

The purpose for releasing this records is: _____

We will automatically send information to referring providers and other relevant consultants to ensure coordination of your care with your healthcare team.

You may wish family/friends/Power of Attorney to have access to your records in event of an emergency. If so, you authorize us to release pertinent medical records to (Name, relationship, address, phone number):

_____

I release Sonoran Sky Surgical, PLC from any liability arising from the provision of this information to the above-stated, provided the release is performed in accordance with the applicable law. I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release. I understand that this Authorization may be revoked in writing at any time and this will apply only to releases of information made after the date of revocation. This authorization will expire twelve (12) months from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of the authorization upon request.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____