AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ D.O.B. _____

The person named above is/has been a patient of:

Sunset Clinic
7609 E. Pinnacle Peak Rd, Suite 9
Scottsdale, AZ 85255

Please send a copy of patient's health information to:

Health Care Provider or Facility: _____

Address: _____

Phone: _____

Fax: _____

IMPORTANT:
If the health information is not being sent directly to a health care provider/facility, a $25 processing fee is required.

Credit Card Number: _____

Expiration Month/Year: _____

Security Code: _____

Authorization for Release of Information, and (if applicable) Credit Card Charge for $25 Processing Fee:

_____

Printed name of Patient or Authorized Representative

_____ _____

Signature of Patient or Authorized Representative | Date

If not signed by patient, indicate relationship of authorizing person to patient: _____