

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: _____

This message is confidential, intended only for the named recipient(s) and may contain information that is privileged or exempt from disclosure under applicable law. If you are not the intended recipient(s), you are notified that the dissemination, distribution or copying of this message is strictly prohibited. If you receive this message in error, please notify the sender listed above and discard this fax. Thank you! - Sunset Clinic