AUTHORIZATION TO RELEASE MEDICAL RECORDS

(in compliance with HIPAA)

PATIENT INFORMATION*

Name	Birthdate

*If patient is a minor or unable to sign for themselves, please see the other side of this form.

I hereby request the release of my records from:

Provider/Organization to Release Information		
4C Medical Group		
Address: 9590 E. Ironwood Sq. Dr. Suite 125		
City: Scottsdale	State: AZ	Zip Code: 85258
Phone Number: (480) 455-3000	Fax Number: (866) 819-6115	

I authorize that my records be released to:

Provider/Organization to Receive Information		
Dr. Rajesh Soni / Soni Family Medicine		
Street Address: 14825 E. Shea Blvd., Suite 105A		
City: Fountain Hills	State: AZ	Zip Code: 85268
Phone Number: (480) 385-9896	Fax Number: (480) 248-9544	

My entire medical record may be released including the following health information:

Office notes, patient histories, lab and other test results, pharmacy and prescription records, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.

I further understand that my medical records may include one or more of the following, and authorize the release of this type of information:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The above provider/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of change of doctor, specialist referral, workers compensation, insurance purposes, legal investigation, individual request, etc.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above provider/organization has relied on the use or disclosure of my health information. My treatment or payment for my treatment cannot be conditioned on my signing this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Legal Representative:	Date Signed:	Description of Personal Representative's Authority*:

***IF APPLICABLE:**

Name of Guardian or Legal Representative		
Address		
City	State	Zip Code
Phone Number	E-mail	