Desert Pulmonary & Sleep Consultants, PLC

Main Office
3303 East Baseline Road, Suite 208
Gilbert, AZ 85234
480-962-1650(P) 480-962-1883(FAX)

Sleep and Diagnostic Center
2730 South Val Vista Drive, Suite 155
Gilbert, AZ 85295
480-917-1996(P) 480-917-3960(FAX)

Authorization for Release of Protected Health Information

I hereby authorize the release of photocopies of the following "Medical Records" in possession of Desert Pulmonary & Sleep Consultants for the purposes hereof, "Medical Records", shall include: All confidential HIV-related information, confidential communicable disease-related information (as defined in A.R.S. Section 36-661), confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 et.Seq), and confidential mental health diagnosis and treatment information. The release of your medical records are intended only for the purposes and parties described below.

Patient's Name_____

Address_____**City**_____

State_____**Zip**_____**Phone**_____**DOB**_____

Which records are needed:_____

Reason for transfer/request:_____

I, the undersigned, do hereby authorize and direct you to

☐ Furnish record ***TO*** Desert Pulmonary & Sleep Consultants, PLC from:

☐ Release records ***FROM*** Desert Pulmonary & Sleep Consultants, PLC to:

Name_____

Address_____City_____

State_____Zip_____Phone_____Fax_____

Check how records are to be received: Mail _____Pick-up_____Fax_____
(If **all** records are requested, **DPSC will not fax records)**

I understand that my request will be processed within 30 days or the timeframe set forth by state law, whichever is less. A copy of this authorization is as valid as the original and will expire 1 year from the date below.

Print Name _____

Signature _____

Witness _____

Date _____