Surprise Health Center, PLLC

MEDICAL REQUEST

Patient Name: ______________________________ (Printed) Date of Birth: ______________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorization the disclosure of my health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand this could include (if applicable): ADIS/ HIV, Mental health or psychiatric care, substance or alcohol abuse treatment.

Signature: ______________________________ Date: ______________

(Patient/ Legal Representative)

Authorizing:

Name of Organization: ______________________________

Ph: ______________________ Fx: ______________________

a phone number OR fax must be provided in order to request records

To Release the following:

____ Most Recent office notes, labs, imaging

____ Office Visit Notes for dates: ______________________

____ Labs for dates: ______________________

____ Imaging (x-rays, MRIs, CTs, etc.) for dates: ______________________

____ Immunization Records

____ ALL records (office notes, labs, imaging)

____ Other: ______________________________

To:

Surprise Health Center

14973 w. Bell Rd.

Surprise, AZ 85374

Ph 623 815 2900 **Fx 623 583 1319**

Practitioner (*circle*):

Ravi Bajpai, DO **Shelly Tellman, NP** **Sorana Pop, NP** **Ameet Shuckla, PA** **Onkar Bhowra, MD**