AUTHORIZATION TO OBTAIN RECORDS - CONTINUATION OF CARE

I, **NAME**_____________ _______________ _,**DOB**,____________, authorize Thunderbird Internal Medicine Summit Medical Group Arizona to obtain my medical records which may include information concerning communicable diseases such as HIV, AIDS, mental illness (except psychotherapy notes), chemical/alcohol dependency and Diagnosis and treatment information from:

Doctor Name(First and Last):____________________________________Practice Name:_________________________________

Address:____

Phone: ____Fax: ____

Social Security #:_____________________Disclosure of information is requested for the purpose of:________________________

Records are to be released to the following (check one):

- ❑ Joel Metelits, M.D.
- ❑ Narendra Godbole, M.D.
- ❑ Trinh Doan, M.D.
- ❑ Karen Wetherell, M.D
- ❑ Ethiopia Gebeyehu, M.D.
- ❑ Robert Swierupski, M.D.
- ❑ Angela Felix, D.O.
- ❑ Prineet Tung, M.D.
- ❑ David Warfield, M.D.
- ❑ James Carpenter, M.D.
- ❑ Kim Lucas, M.D.
- ❑ Mindy Taber, M.D
- ❑ Vicky Chen-Yang, M.D.
- ❑ Grace Yu, M.D
- ❑ Dan Schlosser, M.D.
- ❑ Joshua Millstein, D.O.
- ❑ Kimberly Brandstetter, M.D.
- ❑ Thomas Habiger, M.D.
- ❑ Darry Johnson, M.D.
- ❑ John Tassone, DPM
- ❑ Deborah Blaylock, AuD
- ❑ Sharon Alguire, PA-C
- ❑ Christina Szabo, ANP-C
- ❑ Jessica Lucente, PA-C
- ❑ Samantha Murphy, PA-C
- ❑ LuAnne Kelly, ANP-BC

Check what is being requested below. <u>Please be sure to include date of service (MM/YY).</u>

Test/Report	Date	Test/Report	Date
❑ Colonoscopy		❑ Immunization Records	
❑ Consultation reports		❑ Lab reports	
❑ Dexa/Bone Density		❑ Mammogram	
❑ Echocardiogram		❑ Medical Summary	
❑ EEG report		❑ Medication List	
❑ EGD		❑ Operative report	
❑ EKG report		❑ Pap	
❑ EMG/Nerve study		❑ Pathology report	
❑ ER Consultation		❑ PFT	
❑ H/P w/ Problem List		❑ Sleep Study	
❑ Hospital Consultations		❑ Other Diagnostic Imaging (list):	
❑ Hospital Discharge Summary		❑ Other not listed (list):	

Patient/Guardians Signature:________________________________ Date: ____

Witness's signature:_______________________________________ Date: ____

EXPIRATION DATE OF THIS AUTHORIZATION: ___________

For the protection of the patient-this is not a valid release if not witnessed and if not entirely complete. This authorization is valid for 6 months unless revoked in writing. It cannot be revoked retroactively for information already released. **If any portion of this authorization is returned incomplete, there will be a delay in the processing of this request until completion.**

NOTICE TO THE PATIENT: Please make arrangements with your previous physician(s) office to obtain any records for personal use. Thunderbird Internal Medicine does not provide such copies to our patients. Our physicians only retain what they feel is medically necessary from these records, thus we do not retain a complete set. In addition, prior to providing our office with any records you may already have, please retain a copy for yourself.

<u>Please fax back this form with records attached to 602-938-6069. Thank you</u>