OrthoArizona

www.OrthoArizona.org
602.648.5444

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the release of the following information from the health record of:

Patient name: *(First, Last)* _____ Date of birth: _____/_____/_____

Primary address: _____ City: _____ State: ____ Zip: _____

Date(s) of service: _____

How would you like to receive this information? **Please note, we ***DO NOT EMAIL*** patient records**

- ☐ Patient pick up
- ☐ Mail

Information Requested:

- ☐ Medical History
- ☐ Discharge Summary
- ☐ Consult
- ☐ Operative Reports
- ☐ Lab / Radiology Exams / EKG
- ☐ Complete Record
- ☐ Progress Notes
- ☐ Other: _____

Purpose:

- ☐ Self
- ☐ Attorney / Legal
- ☐ Insurance
- ☐ Continued Medical Care
- ☐ Disability
- ☐ Worker's Comp
- ☐ Other: _____

Information Released **FROM**: Company / Person / Family: _____

Address: _____

Information Released **TO**: Company / Person / Family: _____

Address: _____

I understand that information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV) and other communicable disease, behavioral health care / psychiatric care, and treatment of alcohol or drug abuse. My signature authorizes release of any such information. I understand that OrthoArizona will not discontinue or deny treatment based on my signing or not signing this authorization. This authorization shall be considered invalid after six (6) months from the date of signing. I may revoke this authorization at any time by providing the physician written notice of revocation. However, I may not revoke the authorization retroactively for information already released. I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release OrthoArizona, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized.

COPY OF RECORDS MAY TAKE UP TO 30 BUSINESS DAYS TO OBTAIN, PLEASE LET US KNOW IF THERE ARE EXTENUATING CIRCUMSTANCES!

_____ _____

Patient Signature or Parent / Legally Authorized Representative Date

_____ _____

Staff Signature Date

PLEASE COMPLETE THIS FORM AND RETURN IT:

- In Person: Your preferred OrthoArizona location
- Fax: 602-648-5445