

**AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION FROM
ORTHOARIZONA-AOA**

Patient Name: _____ **Date of Birth:** _____ **PID#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

I hereby authorize:

OrthoArizona-Arizona Orthopaedic Associates at Gateway
690 North Cofco Center Court, #290
Phoenix, AZ 85008
Phone (602) 631-3161 Fax (602) 631-3162

To release confidential information from my/my minor child's medical record to:

Name: _____

Address: _____

Phone: _____ **Fax:** _____

The specific information I wish to have released is (include dates of treatment):

In addition to the general authorization to release confidential medical record information, I authorize the release of the records described as the following:

Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases. YES NO

Drug and alcohol treatment. YES NO

Psychological/psychiatric information, including diagnosis and treatment. YES NO

The release is at my request for:

Further Medical Care Attorney/Legal Disability Determination
 Personal Use FMLA/Employer Other: _____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

Signature: (Parent or Legal Guardian if Minor Child)

Date

Witnessed By:

Date:

Expiration Date: