AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION TO ORTHOARIZONA-AOA

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

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

I hereby authorize:

Name:_____

Adress:_____

Phone:_____**Fax:**_____

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

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

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.

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: _____