AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Name: _____ Date of Birth: _____

Address: _____

I hereby authorize:

Name of Practice: _____ Telephone: _____

Name of Physician: _____ Fax: _____

Address of Practice: _____

_____

To release confidential information from my (or my minor child's) medical record to:

Desert Orthopedic Specialists, PC
2905 West Warner Road, #23
Chandler, AZ 85224
Phone (480) 345-2031 Fax (480) 491-2767

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 disease.	[ ] 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: _____