

Arizona Orthopedic & Fracture Surgeons

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602-230-1400 Fax 602-230-7676

Authorization for Release of Medical Record Information

Name: _____ Date of Birth: _____

Address: _____ Account #: _____

City: _____ State: _____ Zip: _____ Phone #: _____

I hereby authorize:

Name: _____ Address: _____
City: _____ State: _____ Zip: _____

To disclose information from my/my minor child's medical records to:

Name: _____ Address: _____
City: _____ State: _____ Zip: _____

I hereby authorize redisclosure of this information to:

Name: _____ Address: _____
City: _____ State: _____ Zip: _____

This information is needed for the following reason:

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

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

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion or mental health treatment. Separate consent must be given before this information can be released.

- I DO consent to have this information disclosed.
- I DO NOT consent to have this information disclosed.

Signature: (Parent or Legal Guardian if Minor Child)

Date

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

- I DO consent to have this information disclosed.
- I DO NOT consent to have this information disclosed.

Signature: (Parent or Legal Guardian if Minor Child)

Date

Witnessed By: _____

Date: _____

Expiration Date: _____

(Processed By: _____/Date: _____)