OrthoArizona

www.OrthoArizona.org
602.648.5444

Patient Name: *(First, Last)* _____ Date of Birth: _____

Full Address: _____ Phone Number: _____

How should the requested information be sent: ***Please note, we DO NOT EMAIL patient records****

☐ Secure Patient Portal ☐ Mail ☐ Patient Pick Up: Location _____

I request and authorize OrthoArizona to: **(Check ONE below)**

☐ Request from *OR* ☐ Release to

Name: _____

Mailing Address: _____

Phone: _____

Information being requested:

☐ Complete Records: (This includes every document in your chart, from start of care to present)

☐ Office Visit Notes *(includes x-ray reports)*
☐ Physical Therapy Notes
☐ Operative Reports
☐ Non X-ray Reports *(includes MRI, CT)*

☐ Images: Check one:
☐ Disc
☐ Paper
☐ Other: _____

Purpose:

☐ Personal Use ☐ Continued Medical Care ☐ Attorney / Legal ☐ Insurance

☐ Disability Company ☐ Worker's Compensation ☐ Other: _____

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***
***** Physical signature required***

_____ _____
Patient Signature or Legally Authorized Representative Date:

_____ _____
Printed Name of Legal Authorized Representative Staff Members Name

Please complete form in its entirety and return one of the ways below:

* Email: medicalrecords@orthoarizona.org * Fax 480.833.2136