AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name _____ Date of Birth _____

Telephone _____ Cell Phone _____

I request and authorize _____

To release healthcare information of the patient named above to:

Name Sonoran Spine Center

Address 1255 W. Rio Salado Parkway, Suite 107, Tempe, AZ 85281

City Tempe State AZ Zip Code 85281

Telephone No 480-962-0071 FAX 480-962-0590

This request and authorization applies to healthcare information relative to my diagnosis, treatment, prognosis, and/or recommendations, as well as other data pertinent to my condition during the past two years.

- ☐ Office Notes
- ☐ Operative Notes
- ☐ Radiology Notes
- ☐ Laboratory Notes
- ☐ X-ray Films
- ☐ Itemized Billing
- ☐ Complete Medical Records
- ☐ Other _____

I authorize the release of photocopies of the medical records and/or X-ray films in your possession or control **FOR THE PURPOSE HEAROF:** "MEDICAL RECORDS" AND "X-RAYS FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV RELATED INFORMATION, CONFIDENTIAL COMMUNICABLE DISEASE RELEATED INFORMATION 9AS DEFINED IN A.R.S.SECTION 36-661). CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

Signature of Patient/Parent or Guardian _____ Date Signed _____

Relationship to Patient _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED