SONORANSPINE

Expertise in Spine • Exclusively Spine

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name ______________________________ Date of Birth ________________

Telephone ______________________________ Cell Phone ________________

I request and authorize **Sonoran Spine Center** ______________________________

To release healthcare information of the patient named above to:

Name ______________________________

Address ______________________________

City ______________________________ State ________ Zip Code ________

Telephone ______________________________ FAX ______________________________

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 ______________________________

PLEASE ALLOW 7-10 BUSINESS DAYS FOR COMPLETION
THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

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