SPARCC
Sports Medicine • Rehabilitation • Concussion Care

Records Release
(520) 222-8076
www.sparcctucson.com

Authorization to Release Medical Records

Patient Name _____ Date(s) of Service_____

Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

❒ Continuing Medical Care
❒ Insurance
❒ Legal purposes
❒ Military
❒ Personal Use
❒ School
❒ Social Security/Disability
❒ Other _____

INFORMATION TO BE RELEASED:

❒ History & Physical
❒ Operative Reports
❒ Lab/Path Reports
❒ Consultation Report
❒ Discharge Summary
❒ X-Ray Reports/Images
❒ Emergency Room Record
❒ Other _____

The above information may be released:

TO:

Dr. Mo Mortazavi, Dr. Jon Minor, Leslie Streeter, SPARCC Sports Medicine, Rehabilitation, and Concussion Center
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

(520) 222-8076
Phone

(520) 300-7156
Fax

5199 E. Farness Dr. Tucson AZ 85712
Address (Street, City, State, Zip)

FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

_____
Phone

_____
Fax

_____
Address (Street, City, State, Zip)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire

six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

A photocopy of this document is to be considered as valid as the original.

_____	_____
Signature of Patient or Legally Authorized Representative	Date
_____	_____
Printed Name of Patient or Legally Authorized Representative	Relationship to Patient