

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:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Military | <input type="checkbox"/> Social Security/Disability |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Legal purposes | <input type="checkbox"/> School | |

INFORMATION TO BE RELEASED:

- | | | |
|---|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lab/Path Reports | <input type="checkbox"/> X-Ray Reports/Images | |

The above information may be released:

TO:
_____ Dr. Mo Mortazavi & Dr. Jon Minor, SPARCC Sports Medicine, Rehabilitation, and Concussion Center _____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

_____ (520) 222-8076 _____
Phone

_____ (520) 300-7156 _____
Fax

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