

Desert Foot and Ankle, P.C.

1520 S. Dobson Road, Suite 307

Mesa, AZ 85202

480-844-8218 / 480-844-9950

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME: _____ ACCT# _____
Last First MI

PATIENT'S DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PHONE#: _____ FAX#: _____ Email: _____

PATIENT'S ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PLEASE
CHECK
APPROPRIATE
BOX

- I hereby authorize **Desert Foot and Ankle, P.C.** to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.
- I hereby authorize THE PROVIDER LISTED BELOW to send / release photocopies of medical records to the above named patient to **Desert Foot and Ankle, P.C.**

(NAME OF COMPANY / PHYSICIAN / AUTHORIZED PERSON / TO RECEIVE / RELEASE RECORDS)

NAME: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE #: _____ FAX #: _____ Email: _____

FOR PURPOSES OF: _____

FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL:

1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ER SEQ.)
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801)

____ MEDICAL RECORDS OF THE LAST TWO YEARS (and/or)
____ THE FOLLOWING DESCRIBED RECORDS (specify types and dates) _____

This consent will expire (90) days after the signed date below. I may revoke this authorization at any time providing I notify the above listed doctors in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality. **I HEREBY RELEASE DESERT FOOT AND ANKLE, P.C. FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.**

Signature of Patient

Date Signed

Parent/Legally Authorized Representative

Relationship to Patient

Reason patient was unable to sign release: _____

PATIENT 18 YEARS AND OLDER MUST SIGN OWN RELEASE