AZ Spine Disc and Sport
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Medical Records Release/Request From

Patient Name: _____
(Last, First MI) (Previous Name)

Address: _____

Date of Birth: _____ Telephone #: _____ SSN: _____

Reason For Request: _____

Release Records FROM AZ Spine Disc and Sports **TO**:	Release Records TO AZ Spine Disc and Sport **FROM**:
_____ Name	_____ Name
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone Number Fax Number	_____ Phone Number Fax Number

I hereby authorize the release of photocopies of the following medical records in the possession or control of the above named facility, it's employees and/or agents for the purposes hereof, "medical records" shall include all confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information (as 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 genetic testing and mental health diagnosis/treatment information (as defined in A.R.S. Section 12-2801).

Information to be Released:

_____ All Medical Records _____ Radiology Reports _____ Laboratory Reports

_____ Past 2 years _____ Other Records (specify) _____

I may revoke this authorization in writing however if I chose to do so it would not affect any actions already taken by AZ Spine Disc and Sport (AZ Health Centers, PLLC.), based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

This authorization expires within six (6) months from the date signed. If you wish to have the authorization expire before the six (6) months, please indicate the date of expiration: _____.
It is further understood that there may be a fee, payable by the patient for releasing these records.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of patient Date

*A copy of this release shall be as binding as the original.