Hand to Shoulder Surgery & Reconstructive Microsurgery • www.achssurgeons.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

Patient's Name:_____ Date of Birth:_____
Address: _____
City:_____ State: _____ Zip Code: _____
Daytime Phone Number: (___)_____

I authorize Arizona Center for Hand Surgery, P.C. to OBTAIN my records from:

Facility Name/Dr. Name: _____
Facility Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

I HEREBY CONSENT TO THE RELEASE OF ALL MEDICAL RECORDS AND OTHER DOCUMENTATION PERTAINING TO THE MEDICAL CARE RECEIVED IN THIS FACILITY, INCLUDING THE FOLLOWING:

❑ Complete Record	❑ Lab Reports	❑ Therapy Reports	❑ Other_____
❑ Progress Notes	❑ Imaging Reports	❑ Medication Records	_____
❑ Consults	❑ Operative Notes		_____

I UNDERSTAND THAT THIS MAY INCLUDE INFORMATION RELATING TO: (CHECK IF APPLICABLE)

❑ AIDS/HIV ❑ Mental health or psychiatric care ❑ Substance or alcohol abuse treatment

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME, BY PRESENTING A WRITTEN REQUEST TO THE MEDICAL RECORDS DEPARTMENT. I UNDERSTAND THAT REVOCATION **WILL NOT** APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. THIS AUTHORIZATION WILL EXPIRE **ONE YEAR** FROM THE DATE OF SIGNATURE BELOW.

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF MY HEALTH INFORMATION IS VOLUNTARY. I NEED NOT SIGN THIS FORM TO ASSURE TREATMENT. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN *UNAUTHORIZED* RE-DISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.

Patient/Legal Representative Signature: _____ Date: _____

If signed by legal representative, what is the relationship to the patient: _____