DESERT ORTHOPEDIC SPECIALISTS
Jonathan Fox, M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Name: _____Date of Birth:_____ Phone:_____

Email: _____

Mailing Address: _____

I hereby authorize:

Desert Orthopedic Specialists, PC
2905 West Warner Road, #23
Chandler, AZ 85224
Phone (480) 345-2031 Fax (480) 491-2767

To release information from my/my minor child's medical record to ☐ Myself or ☐ Other (complete below)

Name: _____

Address: _____

Phone: _____ Fax: _____

The specific information I wish to have released is: ☐ ALL Records
Records pertaining only to treatment of the: ☐ Hip ☐ Knee ☐ Shoulder ☐ Other: _____

In addition to the general authorization to release confidential medical record information, I authorize the release of the records described as the following:

Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related disease.	☐ YES ☐ NO
Drug and alcohol treatment.	☐ YES ☐ NO
Psychological/psychiatric information, including diagnosis and treatment.	☐ YES ☐ NO

The release is at my request for:

☐ Further Medical Care ☐ Attorney/Legal ☐ Disability Determination

☐ Personal Use ☐ FMLA/Employer ☐ Other:_____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

_____ _____

Signature: (Parent or Legal Guardian if Minor Child) **Date**

For Office Use Only

Verified By:_____ _____

Date

Expiration Date: _____

Please send your signed and complete form to Info@DesertOrthoAZ.com