

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone # \_\_\_\_\_ Cellular # \_\_\_\_\_

I request and authorize \_\_\_\_\_ Sonoran Spine Center \_\_\_\_\_

To release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email (print clearly) \_\_\_\_\_

This request and authorization applies to healthcare information relation to my diagnosis, treatment, prognosis, and/or recommendations, as well as other data pertinent to my condition during the past two years.

- |  |   |
|--|---|
| <input type="checkbox"/> Office Notes      | <input type="checkbox"/> Itemized Billing         |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Complete Medical Records |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> X-Ray Films       |   |

I authorize the release of photocopies of the medical records and/or x-ray films in your possession or control FOR THE PURPOSE HEAROF: "MEDICAL RECORDS" AND X-RAY FILMS' SHALL INCLUDE ALL CONFIDENTIALITY HIV RELATED INFORMATION, 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 CRF SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

Signature of  
Patient/Parent/or Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

PLEASE ALLOW 7-10 DAYS FOR COMPLETION  
THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED