



I, the undersigned, authorize Sonoran Orthopaedic Trauma Surgeons to disclose the information described below to the recipient(s) described below. I understand and agree to the statements and information contained in this authorization.

**PATIENT INFORMATION**

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Other Names During Treatment: \_\_\_\_\_

**RELEASE INFORMATION TO/FROM (Please Circle)**

Please complete this box in order for the request to be processed:

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_ Records Needed by (Date): \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Purpose of Request: Personal  Treatment  Legal  Insurance  Disability  Other   
 Transfer/Reason \_\_\_\_\_

**INFORMATION TO BE RELEASED**

**Section 1:**

- **For Personal Requests**, there will be a \$25.00 flat fee and a \$0.25 per page fee for all requests on paper and there will be a \$10.00 flat fee and a \$0.10 per page fee to mail medical records.
- For Doctor to Doctor Requests, there will be no fee. By default the past two (2) years of pertinent information will be sent. Please provide any specific additional information in Section 2.

**Section 2:** Place a check mark next to the requested records.

Please provide information in my medical records for dates: From: \_\_\_\_\_ To: \_\_\_\_\_  
 History and Physical Examination  Office Visit Notes  
 Laboratory Tests  X-Rays/Imaging Reports  
 Genetic Testing/Studies  
 Other: \_\_\_\_\_

**FORM OF RECORDS**

Please choose:  
 Records on Paper  Mailed Records on Paper

**AUTHORIZATION TO RELEASE PROTECTED**

Required – Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient’s medical records.

Check One		Initial Each Line Below
I <input type="checkbox"/> Do <input type="checkbox"/> Do Not want information on <b>Mental Health</b> to be released		_____
I <input type="checkbox"/> Do <input type="checkbox"/> Do Not want information on <b>HIV Tests and Related</b> information to be released		_____
I <input type="checkbox"/> Do <input type="checkbox"/> Do Not want information about <b>Alcohol and/or Substance Abuse</b> released		_____
I <input type="checkbox"/> Do <input type="checkbox"/> Do Not want information about <b>Communicable Diseases</b> released		_____



Please confirm that you have put a **checkmark and initialed** all the protected information categories above regardless if they are applicable or not. If the form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

- This authorization will expire 90-days from the date appearing above. I understand that I may revoke this authorization at any time by notifying Sonoran Orthopaedic Trauma Surgeons in writing, but if I do, it will not have any effect on the actions Sonoran Orthopaedic Trauma Surgeons took before it received the revocation.
- I understand that under the applicable law the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard.
- Sonoran Orthopaedic Trauma Surgeons may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I understand that I may inspect or copy the information that is used or disclosed.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative executes this authorization, then the authorization must contain a description of the representatives authority to act for the individual, e.g., “parent” or “guardian ad litem”

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_