Authorization to Release Medical Records

I authorize a copy of the medical information for

_____DOB:_____
Full Name

From:	**To be released to:**
Name: _____	Spine & Orthopedic Specialists
Address: _____	20401 N. 73rd Street, Suite 255
City, State, Zip: _____	Scottsdale, AZ 85255
Phone #: _____	480-353-0446-p/1-877-715-6428-f

This request and authorization applies to Healthcare information relative to my diagnosis, treatment, prognosis, and/or recommendations, as well as other data pertinent to my condition during the past two years. By marking the spaces below, I specifically authorize the release of the following medical records, if such records exist:

( ) Medical records needed for continuity of care
( ) X-rays
( ) MRI, CT, Bone Scan, Ultrasound reports
( ) Laboratory Reports
( ) Physical therapy reports
( ) Itemized Billing
( ) Other (please specify) _____
( ) Please send the entire medical record (all information) to the above recipient.

Reason for request: _____

I understand that the information disclosed as directed by this authorization is subject to re-disclosure by the recipient and no longer protected under federal law.

I understand my information may be mailed or faxed depending on the urgency of the request.

I understand that this authorization may be revoked in writing at any time, except to the extent that action had been taken in reliance on the authorization. Unless otherwise revoked, the authorization will expire 180 days from the date of signing.

_____ _____
Signature of patient or person authorized by law and relationship to patient Date

Relationship to Patient: _____