Davis Orthopaedics

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Last 4 of social security #: XXX – XX - _____

I, _____ give permission to ____Davis Orthopaedics_____
(Patient Name) (Releasing Party)
3237 N Windsong Drive Prescott Valley, AZ 86314 (P) 928-772-5320 (F) 928-772-5319_____
(Releasing Parties address, phone, and fax number)

to release the selected my medical records to _____
(Receiving Party)
_____
(Receiving Parities address, phone, and fax number)

Records Content:

- ☐ All
- ☐ Davis Othopaedics (Release only)
- ☐ Other Specify: _____

Dates:

- ☐ All
- ☐ Past two years

Comments:

_____

_____

The purpose of this Authorization for Use and Disclosure of Protected Health information is to allow healthcare providers to disclose protected heath information to Davis Orthopaedics, LLC. Federal and state law prohibits healthcare providers from sharing my health information without my permission except in certain situations, such as continuity of care. By signing this Authorization, I am giving permission for my healthcare providers to share my health information.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____