Medical Records
Phone: 928-226-2950
Fax: 928-774-7767

Northern Arizona ORTHOPAEDICS
Outcomes by HOPCo

Authorization For Use or Disclosure of Medical Record Information

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information To: (Please check one or both)

☐ **Mail Copies To:** **(OR)** ☐ **Discuss Medical Information:**

○ I hereby authorize **Northern Arizona Orthopaedics** to release my medical record information to: Name/Facility: _____ Attention: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	○ I hereby authorize **Outside Providers Office** to release my medical record information: Name/Facility: _____ Releasing To: **Northern Arizona Orthopeadics** Attention: **Medical Records** Address: **1485 N. Turquoise Dr., Ste. 200** City: **Flagstaff** State: **AZ** Zip: **86001**

Purpose of Request: ○ Personal ○ Workers' Compensation ○ Insurance ○ Legal ○ Disability Determination

Information to be Released: (Please check only what applies to your request)

○ Please provide **ALL** medical records

○ Please provide the following records:
____Office Visits____Labs____MRI
____Operative Reports____EMG/NCV

○ Please provide CD of X-ray images

○ Please return films provided by patient

○ Other: _____

If no option is selected recipient will receive 30 pages of the most recent medical records.

Check all that apply. Please note that all unchecked boxes will waive your right to deny release of information.

I DO NOT Authorize release of information related to ☐ AIDS ☐ HIV ☐ Psychiatric care or psychological assessment ☐ Treatment of drug or alcohol abuse

Please Sign and Date Here:

Patient's Signature **Date**

Parent/Legally Recognized Representative **Date**

This authorization is valid for **12 months** from the date of signature. By signing you agree that you have the right to cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. The information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. Your treatment or continued treatment by Northern Arizona Orthopeadics and its affiliates is no way conditioned on whether or not you sign the authorization and that you may refuse to sign it. ***We have up to 2 weeks to process your records from date received.***