

**AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION FROM
AOA@GATEWAY**

Patient Name: _____ Date of Birth: _____ PID#: _____
Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize:

Arizona Orthopaedic Associates at Gateway
690 North Cofco Center Court, #290
Phoenix, AZ 85008
Phone (602) 631-3161 Fax (602) 631-3162

To release confidential information from my/my minor child's medical record to:

Name: _____
Address: _____
Phone: _____ Fax: _____

The specific information I wish to have released is (include dates of treatment):

In addition to the general authorization to release confidential medical record information, I authorize the release of the records described as the following:

- | | |
|--|--|
| Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases. | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Drug and alcohol treatment. | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Psychological/psychiatric information, including diagnosis and treatment. | <input type="checkbox"/> YES <input type="checkbox"/> NO |

The release is at my request for:

- | | | |
|---|---|---|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Disability Determination |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> FMLA/Employer | <input type="checkbox"/> Other: _____ |

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

Signature: (Parent or Legal Guardian if Minor Child) _____

_____ Date

Witnessed By: _____

Date: _____

Expiration Date: _____