DESERT HAND AND PHYSICAL THERAPY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ MEDICAL RECORD#_____

ADDRESS: _____ PHYSICIAN: _____

_____ _____

SOCIAL SECURITY# _____ DATE OF BIRTH: _____

WORK PHONE # _____ HOME PHONE # _____

I HEREBY AUTHORIZE DESERT HAND AND PHYSICAL THERAPY TO SEND/RELEASE PHOTOCOPIES OF MEDICAL RECORDS CONCERNING THE ABOVE NAMED PATIENT TO:

_____

(NAME OF COMPANY OR PERSONS AUTHORIZED TO RECEIVE RECORDS)

_____

(FULL ADDRESS)

I will authorize the release of photocopies of the following records in the possession of control of Desert Hand and Physical Therapy, LLC, its employees and/or agents. For the purposes hereof, Medical records shall include all confidential HIV-Related information (As defined in A.R.S Section 36-661), confidential communicable diseases-related information (As defined in A.R.S Section 36-661), confidential alcohol or drug abuse-related information (As defined in 42 CFR Section 2.1 ET Seq.), and confidential mental health diagnoses/treatment information.

MEDICAL RECORDS (CHECK ONE)

_____ ALL MEDICAL RECORDS OF THE PAST 2 YEARS OF TREATMENT

OR

_____ THE FOLLOWING DESCRIBED RECORDS ONLY (SPECIFY TYPES AND DATES)

THIS CONSENT WILL EXPIRE IN 60 DAYS AFTER THE SIGNED DATE BELOW. I HAVE GIVEN MY CONSENT FREELY, VOLUNTARILY, AND WITHOUT COERCION. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME PROVIDING I NOTIFY DESERT HAND AND PHYSICAL THERAPY LLC. IN WRITING TO THAT EFFECT. I UNDERSTAND THAT ANY RELEASE WHICH WAS MADE PRIOR TO REVOCATION WITH THIS AUTHORIZATION NOT CONSTITUTE A BREACH OF MY RIGHTS TO CONFIDENTIALITY. I UNDERSTAND THAT A PHOTOCOPY OF THIS AUTHORIZATION IS CONSIDERED ACCEPTABLE IN LIEU OF THE ORIGINAL.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/LEGALLY AUTHORIZED REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: _____

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