ARROW SURGICAL ASSOCIATES, P.C.

10599 N. Tatum Blvd. Ste. F-151
Paradise Valley, AZ 85253
Ph. 602-977-0136
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Authorization to release medical records

Date Received:_____
Date Released:_____
Released By:_____

(Please Print)
Patient Name:_____D.O.B_____SS#:_____

I authorize: _____
Organization/Agency

_____
Address City State Zip Code

To release Information From my Medical Records to: _____
Organization/Agency

_____
Address City State Zip Code

The type of information to be disclosed includes:

☐ Progress Notes
☐ Operative Report(s)
☐ Pathology Report(s)
☐ Ancillary Report (s) ☐ EKG ☐ EEG ☐ Lab ☐ X-Ray

☐ Other:_____

If applicable, the undersigned further authorizes Arrow Surgical Associates, P.C. to disclose a copy of records pertaining to:

1. Testing and/or treatment for AIDS and AIDS related diseases
2. Treatment for psychiatric illness: and/or
3. Treatment for drug/alcohol abuse

This authorization shall be considered invalid after 60 days. I may revoke this authorization at any time by providing Arrow Surgical Associates with written notice of revocation. However, I may not revoke the authorization retroactively for information already released.

I waive all provisions of law and privilege relating to the disclosures hereby authorized.

_____ _____
Signature of Patient Date

Note: In the case a patient is physically unable to sign this authorization; he/she should place And "X" on the signature line and have his/her attestation witnessed.

_____
Relationship to Patient