DESERT ORTHOPAEDIC CENTER

Experience. Excellence.

AUTHORIZATION TO RELEASE HEALTHCARE RECORDS

Please print legibly or type.

Patient Name: _____ DOB: _____

Address: _____
Number Street City State Zip

Phone: _____

_____ I hereby authorize Desert Orthopaedic Center to copy and **release information to the following patient representative.**

Patient Representative Name: _____

Patient Representative Address: _____

Patient Representative Phone: _____

My representative or I will pick up copies at the following office location:

❒ Desert Inn ❒ Horizon Ridge ❒ Centennial ❒ Warm Springs ❒ West Charleston ❒ Mail the Records

_____ I hereby authorize Desert Orthopaedic Center to copy and **release information to the following provider.**

Provider Name: _____

Address: _____
Number Street City State Zip

Phone: _____ Fax Number: _____

The following information is requested:

_____ Office Visit Notes, Including Imaging Results
_____ Operative Reports
_____ Physical Therapy Reports
_____ Written Reports for MRI or CT Procedures
_____ A CD of X-Ray, MRI, CT, or Other Actual Images
_____ Billing Information
_____ Other (Please Specify): _____

The information will be disclosed for the following reasons:

❒ Treatment/Continuity of Treatment ❒ At the Request of the Individual ❒ Legal Reasons ❒ Assessment and Evaluation

❒ Other (Please Specify): _____

This authorization will expire ninety (90) days from the date of the signature below or on _____
Date

Authorization may be revoked by notifying the Custodian of Records at Desert Orthopaedic Center in writing.

NOTE: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by Desert Orthopaedic Center.
*Please allow 7 – 14 business days for processing.

Patient Signature: _____ Date: _____

Personal Representative's Signature: _____ Date: _____

Personal Representative's Relationship/Authority: _____

Authorization to Release Healthcare Records rev 11/01/2022

This authorization is voluntary. A refusal to sign will not affect the patient's ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits.

Desert Orthopaedic Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Phone: (702) 731-1616 | Fax: (702) 734-4900