Authorization of Protected Patient Health Information

Patient Last Name First Name Middle

Date of Birth Phone Number

Address City State Zip

I authorize Urgently Ortho to:

Please Choose One: ◯ Release my medical record information to ◯ obtain medical information from

Please Choose One: ◯ Fax ◯ Mail

Name/ Facility Attention:

Address City State Zip

Phone # Fax#

Purpose of Request □ Personal □ Referral □ Legal □ Insurance □ Transfer from Practice

□ Other

Please Select all the specific documents that apply to request:

□ Clinic Notes □ Radiology Reports □ Lab Reports

□ Operative Reports □ History & Physical □ All records

Signature (Patient or Patient's Parent/ Legal Representative) Date

Printed Name of Patient or Patient's Parent/ Legal Representative Relationship to Patient

PLEASE NOTE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY. THANK YOU FOR YOUR COMPLIANCE.

P: 480-530-7575 | F: 602-429-8336