OrthoArizona
Arizona Sports Medicine Center

- ☐ Dr. Gary Waslewski
- ☐ Dr. Douglas Freedberg
- ☐ Dr. Charles Peterson
- ☐ Dr. Destin Hill
- ☐ Dr. Jessica Juntunen

REQUEST FOR RECORDS

Patient Name: ______________________________ Medical Record #: ___________________________

Address: ___________________________________ Date of Birth: ______________________________

___________________________________ Social Security #: ___________________________

Phone Number: ______________________________

I hereby authorize:

Arizona Sports Medicine Center
8630 E. Via de Ventura Blvd, Suite 201
Scottsdale, AZ 85258
Phone: 480-558-3744
Fax: 480-558-3801

To **release/obtain** copies of medical records concerning the patient named above **to/from**:

____
Physician or Person(s)

____
Address City, State Zip

_______________________________________ _______________________________________
Phone Fax

Information to be sent:

☐ Entire Medical Record	☐ Chart Notes	☐ Billing Statement
☐ MRI, EMG or other testing	☐ Mental Health Notes	☐ Operative Report

The authorization will expire 12 months from the date of signature unless the patient has specified a shorter duration.

Shorter duration expiration date: _________________________________ (MM/DD/YY)

I have given my consent freely, voluntarily and without coercion. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

____
Patient's Signature Date

____
Parent/Legal Authorized Representative Date

I hereby authorize the release of copies of any or all medical records and/or x-ray films that are in your possession. For the purposes hereof, "Medical Records" and "X-Ray films" shall include all confidential HIV-Related information (as defined in A.R.S. Section 36-66) confidential communicable disease-related information (as defined in 42 CER Section 21 ET SEQ) and confidential mental health diagnosis/treatment information.