ADVANCED FOOT & ANKLE SPECIALISTS of Arizona

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND/OR INFORMATION

I authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of Advanced Foot & Ankle Specialists of Arizona, PLLC, its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS AND X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN R.R.S. SECTION 36-3661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 (FR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

I authorize Advanced Foot & Ankle Specialists of Arizona, PLLC, to release medical information and/or discuss all matters related to my treatment or care to the entities indicated below. I understand that confidentiality cannot guaranteed.

Primary Care Physician: _____

Other Physicians: _____

_____

Family and/or Other Persons: (Please list name and relationship)

Name: _____Relationship_____

_____Relationship_____

Patient Signature:_____ Date:_____