

TOCA
THE ORTHOPEDIC CLINIC
 ASSOCIATION, P.C.

2222 E. Highland Ave., Suite 300 • Phoenix, Arizona 85016
 602-512-8448 • Fax 602-277-1074

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME: Last First MI ACCT # _____

PATIENT'S DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PHONE # _____ Fax # _____ E Mail _____

PATIENT'S ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PLEASE CHECK APPROPRIATE BOX	<input type="checkbox"/> I hereby authorize TOCA to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.
	<input type="checkbox"/> I hereby authorize THE PROVIDER LISTED BELOW to send / release photocopies of medical records concerning the above named patient to TOCA.

(NAME OF COMPANY / PHYSICIAN / AUTHORIZED PERSON / TO RECEIVE / RELEASE RECORDS)

NAME: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE # _____ Fax # _____ E Mail _____

FOR PURPOSES OF: _____

FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL:

1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.)
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801)

_____ MEDICAL RECORDS OF THE LAST TWO YEARS (and/or)

_____ THE FOLLOWING DESCRIBED RECORDS (specify types and dates) _____

This consent will expire (90) days after the signed date below. I may revoke this authorization at any time providing I notify the above listed doctors in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality. **I HEREBY RELEASE THE ORTHOPEDIC CLINIC ASSOCIATION, P.C. FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.**

Signature of Patient

Date Signed

Parent/Legally Authorized Representative

Relationship to Patient

Reason patient was unable to sign release: _____

PATIENTS 18 YEARS AND OLDER MUST SIGN OWN RELEASE