Authorization for use OR disclose of health information

Patient Name:______________________________________ DOB:____________________

Purpose of Request: ☐ Transfer of care ☐ Personal ☐ Worker's Comp ☐ Insurance ☐ Legal

Type of records requested: ☐ Most recent office note ☐ Last ______(# of visits) office notes ☐ Complete chart

☐ Operative report________________ ☐ Xray Disc ($5.00) ☐ Other:______________________________
(Body part) (Please specify)

Fees

Fax to doctor – FREE **Print from patient portal – FREE** **Print 10 (and under) pages in office – FREE**
Print 11-100 pages in office - $25.00 **Print 100+ pages in office - $35.00** ***ALL requests can take up to 5 days**

☐ REQUESTING RECORDS FROM GRANITE ORTHOPAEDICS TO:

I,______________________________, authorize Granite Orthopaedics to **release** health information to:
(PATIENT NAME)

☐ **SELF OR** ____
(Name of person, practice, or entity receiving records)

I would like records to be:

☐ Faxed F#____________________________

☐ Call to pick up Ph#___________________________

☐ Mailed

Address:____

☐ REQUESTING RECORDS BE SENT TO GRANITE ORTHOPAEDICS:

I,______________________________, authorize______________________________,to **release** health
(Patient Name) (Person/office requesting records from)
information to Granite Orthopaedics.

I would like records to be:

☐ Faxed: (928) 777-9975

☐ Call to pick up Ph#___________________________

☐ Mailed: Granite Orthopaedics
2960 N Centre Crt., Prescott Valley, AZ, 86314

Patient Signature: ____ Date: ____________________