AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________________ DOB: _________________

Social Security Number: ____________________________

I request and authorize ____ to release healthcare information of the patient named above to:

Sonoran Hip Center
3126 N Civic Center Plaza
Scottsdale AZ 85251
480.874.2040 ph   4800.874.2041 fx

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information related to the following treatment, condition, or dates:

____

Patient's Signature ____________________________________ Date ___________________

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM SIGNATURE DATE