Dr. Amit Sahasrabudhe

Dr. Erik Dean

REQUEST FOR RECORDS

Patient Name_____ Medical Record #_____

Address_____ Date of Birth_____

_____ Social Security #_____

Phone #_____

I hereby authorize: **AZ SPORTS MEDICINE**
8630 E. Via de Ventura Blvd, Suite 105
Scottsdale, AZ 85258
(P) 480-889-1838
(F) 480-889-1917

To **release/obtain** copies of medical records concerning the above named patient **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 Reports

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 A.R.S. Section 36-661) confidential alcohol or drug abuse related information (as defined in 42 CER Section 21 ET SEQ) and confidential mental health diagnosis/treatment information.