Center for Minimally Invasive and Robotic Surgery
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AUTHORIZATION FOR RELEASE OF INFORMATION

Requests for records will be mailed within 9 working days from the date this request was received.
If the patient was seen in the office the same day this form is received the records will be mailed within 14 working days. Emergency requests will be faxed to the doctor's office or medical facility.

The following sections must be completely filled out for this to be processed.

Patients Name Last First
MI

Address City
State Zip

Date of Birth SS#
Phone Number

I authorize Arizona General Surgery Specialist, P.C. to:
____ Release information to patients listed above
____ Release information to or ____ Obtain information from

The following sections must be completely filled out for this request to be processed.

Physicians/ Insurance Company Phone Number
Fax Number

Address City
State Zip

____I Do ____ I Do Not authorize the facsimile (fax) transmission of the above records

I understand that the release of all my medical records may or may not include information about drug and alcohol abuse and that this authorization shall expire without my express revocation 3 months from the date written below (60 days for drug / alcohol abuse treatment records). A photostatic copy of this authorization shall be considered as effective and as valid as the original.

Signature of Patient
Date

Signature of authorized person/ witness
Relationship to Patient

In case of a patient who is physically unable to sign this authorization, he/ she should place a "X" on the signature line and have his/ her assent witnessed.
Jam 07/24/07