ROBERT A. MILESKI, M.D.

PHOENIX
ORTHOPEDIC
G R O U P

FELLOWSHIP TRAINEDORTHOPEDICS
SPECIALIZING IN SPORTS MEDICINE
ARTHROSCOPIC SURGERY KNEE&
SHOULDER FOOT& ANKLE
TRAUMA& FRACTURECARE
JOINT REPLACEMENT

SERVINGARIZONA'S ORTHOPEDICNEEDS

MEDICAL RECORDS AUTHORIZATION

Patient Name/Address

Phone Number

I AUTHORIZE PHOENIX ORTHOPEDIC GROUP TO RELEASE OR RECEIVE INFORMATION

NAME TELEPHONE FAX

ADDRESS CITY ST ZIP CODE

MAILED_____ PICK UP_____ FAXED_____

Please release the following information from my medical records;

_____Complete file _____Hospital records _____X-Ray or MRI_____Itemized billing_____ DOS_____

The undersigned herby authorizes the physicians to provide the above named persons with a copy of any and all records, documents, reports, clinical abstract, histories and charts of every kind and description relating to treatment of the patient described above exempt as indicated below.
This authorization shall be considered invalid after one year from the date of the signing. I may revoke this authorization at any time by providing the physician written notice of revocation. However, I may not revoke the authorization retroactively for information already released.
In furtherance of this authorization I hereby waive all provisions of the law and privilege relating to the disclosures herby authorized.

Patient Signature
Parent/Legal Authorized Representative

Relationship to patient

Date

The purpose of this Request (please check ALL that apply)

Further Medical Care_____Insurance_____Disability_____Self_____Other_____

MAIN FAX 602-266-6991

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