DAVIS ORTHOPAEDICS
MARK B. DAVIS, D.O.

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient name: _____

Address: _____

Phone: _____ Date of Birth: _____

I authorize the custodian of records of:

Davis Orthopaedics, LLC
3237 N. Windsong Drive
Prescott Valley, AZ 83614
Phone: 928-772-5320
Fax: 928-772-5319

To release the following information (check all that apply):

_____ All Records	_____ Billing Records
_____ Office notes (previous 2 years)	_____ Pharmacy/Prescription records
_____ Laboratory/pathology records (previous 3 years)	_____ Other _____
_____ Radiology Records (previous 3 years)	_____ HIV/AIDS

Please send the records to:

_____

Address: _____

_____

Phone/Fax: _____

_____ _____
Signature of patient (or Legal Guardian) Date

_____ _____
Printer name of patient representative Representative's authority to sign for patient (i.e. parent, guardian, POA, exectutor)

This authorization shall not be valid for greater than one year from the date of signature