GRANITE ORTHOPAEDICS

Authorization for use OR disclosure of health information

Patient Name: _____ DOB: _____

Purpose of Request: ☐ Transfer of care ☐ Personal ☐ Worker's Comp ☐ Insurance ☐ Legal

Type of records requested: ☐ Most recent office note ☐ Last ____ (# of visits) office notes ☐ Complete chart

☐ Operative report ☐ Xray Disc ($5.00) ☐ Other: _____(Body part)
(Please specify)

Fees

Fax to doctor – FREE Print from patient portal – FREE Print 10 (and under) pages in office – FREE
Print 11-100 pages in office - $25.00 Print 100+ pages in office - $35.00 *ALL requests can take up to 5 days

☐ **REQUESTING RECORDS FROM GRANITE ORTHOPAEDICS TO:**

I, _____, authorize Granite Orthopaedics to **release** health information to:
(PATIENT NAME)

☐ **SELF OR** _____
(Name of person, practice, or entity receiving records)

I would like records to be:

☐ Faxed F# _____

☐ Call to pick up Ph# _____

☐ Mailed - Address: _____

☐ **REQUESTING RECORDS BE SENT TO GRANITE ORTHOPAEDICS:**

I, _____ authorize _____, to release health
(Patient Name) (Person/office requesting records from)
information to Granite Orthopaedics. **I would like records to be:**

* Please provide fax #: _____ and Address _____ of the office where you would like your records released from. *

☐ Faxed: (928) 777-9975

☐ Call to pick up Ph# _____

☐ Mailed: Granite Orthopaedics (2960 N Centre Court., Prescott Valley, AZ, 86314)

Patient Signature: _____ Date: _____