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Release of Medical Records

Have your health information sent to another Provider

Date: ___ / ___ / ___

Patient: _____ DOB: ___ / ___ / ___

Address: _____

SSN: _____ Phone: _____

Send to: Name _____

Street _____

City/State/Zip _____

email _____

Phone: _____ Fax: _____

Send the following information to above recipient:

Office notes: ___ Op Reports: ___ X-Ray reports: ___ Lab reports: ___

By signing below, I hereby release Advanced Knee Care, its physicians and employees from any and all liability for fulfilling this authorized request for medical records/x-rays. This authorization includes ALL confidential information in my file, including HIV, communicable disease, alcohol/ drug abuse and genetic testing information. I understand that I may revoke this authorization at any time by notifying Advanced Knee care in writing.

THIS AUTHORIZATION WILL EXPIRE IN 1 YEAR AFTER SIGNED DATE.

Patient Signature: _____ Date: ___ / ___ / ___