

REQUEST/AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: PATIENT REGISTERED AS: _____
DATE TREATED BY YOU: _____
BIRTHDATE: _____
PREVIOUS NAME: _____

The above named patient is undergoing treatment at this hospital/clinic and the attending physician Would appreciate receiving the following information:

- _____ 1) Summary Report
- _____ 2) History/Physical
- _____ 3) Operative Report(s)
- _____ 4) Tissue Report(s)
- _____ 5) X-Ray Report(s)
- _____ 6) Laboratory Report(s)
- _____ 7) EKG Report(s)

I hereby authorize any hospital, any physician, or other person who has attended me to furnish the Above requested medical information, including the following:

This authorization is valid for ninety (90) days unless revoked by me.

**Patient's Signature or
Legally Authorized Representative**

Date Signed

Witness's Signature

Please mail or fax the records to the below named physician at the below address and/or fax. We appreciate your time and attention to this matter.

**VALLEY ORTHOPEDICS, PLC
Lawrence P. Shank M.D
Gregory H. Sirounian M.D
Douglas B. Mangan M.D
Grant D. Padley, D.O.
Kris Parchuri, D.O.**

**13555 W McDowell Rd #302 Goodyear, AZ 85395
3815 E. Bell Rd. Suite 2300 Phoenix, AZ 85032
Phone (623) 882-1292 FAX (623) 882-8184**