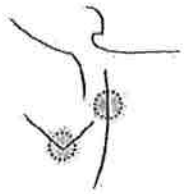
# The **Joint Replacement Center** of **Scottsdale**

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**Medical Records Request/Release**

I (print name)_____ authorize the use of disclosure, of the named individual's health information, as described below and any specific items that may be requested from my file. The above named individual, or organization are authorized to **send or receive** the disclosure. This authorization includes my entire file, or special requested documents below.

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASES, INCLUDING BUT NOT LIMITED TO, AQUIRED IMMUNODEFICIENY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND DRUG ABUSE.

**Please send records**

**From:** _____ **To:** _____

_____ _____

_____ _____

Patient Name: _____
Date of Birth: _____

Special Instructions: _____

Patient Signature: _____ Date: _____