Steingart Orthopedics, P.C.

4045 E Bell Rd, Suite 105
Phoenix, Az 85032

Authorization to Release/ Obtain Medical Records

Today's Date: ____/____/____

Patient name: _____

Date of Birth: ____/____/____ Physician: Dr. Michael Steingart

Phone: _____ Email: _____

Records Released From:

Name: _____

Address: _____

City,State, Zip: _____

Phone: _____ Fax: _____

Records Released To:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Information to be Released/ Obtained:

☐ Complete Medical Records ☐ Lab Reports ☐ Billing Records ☐ Clinical Records Related to:

_____

*Please Note: Any requested records from OUR office will ONLY include Dr. Steingart's medical records. It will NOT include medical records that we have obtained from any other referring doctors due to HIPPA regulations. You must submit that request directly to your medical provider that treated you.

☐ I understand I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization. Unless otherwise revoked, this authorization will expire one (1) year from the signing date.

☐ I authorize Steingart Orthopedics to release or obtain medical records as specified above.

_____ _____ _____

Signature Printed Name Date