Sonoran HIP CENTER

Subsidiary of Sonoran Orthopaedic Trauma Surgeons PLLC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ DOB: _____

Social Security Number: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Sonoran Hip Center
3126 N Civic Center Plaza
Scottsdale AZ 85251
480.874.2040 ph 4800.874.2041 fx

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information related to the following treatment, condition, or dates:

_____

Patient's Signature _____ Date _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM SIGNATURE DATE