JOHN A. NASSAR, M.D.
Orthopedic Foot & Ankle Surgery

Medical Records/X-ray Release Authorization

Patient's Name: _____ Date of Birth: _____
Phone #: _____ Fax #: _____ Email: _____
Address: _____
City: _____ State: _____ Zip code: _____

Please Check Appropriate Box

- ☐ I hereby authorize Dr. John A. Nassar, MD, PC to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.
- ☐ I hereby authorize the PROVIDER LISTED BELOW to send / release photocopies of medical records concerning the above named patient to John A. Nassar, MD, PC

Name: _____

Address: _____

City/State/Zip: _____
Phone: _____ Fax: _____

FOR THE PURPOSES HEREOF "MEDICAL RECORDS" SHALL INCLUDE ALL

1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ)
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801)

I may revoke this authorization at any time providing I notify the above listed doctors in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality. I **HEREBY RELASE John A. Nassar, MD, PC FROM ALL LEGAL RESPONSIBILTY OR LIABILITY THAT MAY ARISE FROM ANY ACT AUTHORIZES ABOVE. This release expires one year from date signed.**

_____ _____
Signature of Patient Date Signed

Parent/Legally Authorized Reprehensive Relation to patient
Reason patient was unable to sign release_____
PATIENTS 18 YEARS AND OLDER MUST SIGN OWN RELEASE

Board Certified, American Board of Orthopaedic Surgery

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