



CAMELBACK MOUNTAIN

SPORTS MEDICINE & REHABILITATION

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INFORMATION RELEASE AUTHORIZATION

Patient/Acct #:

Birth Date:

I hereby consent to the release and disclosure of my personal health information to:

Name (PLEASE PRINT)

Relationship

For the following purpose:

To allow the above individual(s) to discuss the following with Camelback Mountain Sports Medicine and Rehabilitation staff:

- Appointments
- Payments
- Billing
- Medical Treatment

Expiration Date: one year from date signed.

I understand that I am free to revoke this release authorization at any time by notifying Camelback Mountain Sports Medicine and Rehabilitation L.L.C. in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

Patient/Legal Guardian Signature

Date

Power of Attorney Signature

Date