**Desert Institute for Spine Disorders, PC**
**Duane D.H. Pitt, MD**
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Scottsdale, AZ 85255
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*To request release of medical information please complete and sign this form and return via mail or fax to Medical Records.*

Patient Information

Patient Last Name_____First Name_____MI_____

Street Address_____City_____State_____Zip_____

Date of Birth_____Phone Number_____

DISD has my permission to release information contained in the medical record of the above named patient.

Information Requested (please be specific):_____
_____
_____
_____
Restrictions and/or Exclusions (if any):_____
_____
_____
Purpose of release:_____
_____

DISD will provide the information requested above to the following party:

Name_____

Street Address_____Telephone_____

City_____State_____Zip_____

I hereby authorize Desert Institute for Spine Disorder, (DISD) to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded above. I am aware that DISD cannot control how the recipient uses or shares the information, and those laws protecting its confidentiality at DISD may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 1 year from the signature date. I can however, cancel this authorization in writing anytime.

_____ _____
Signature of Patient (18 years of age or older) Date

_____ _____
Signature of Parent or Guardian (if minor patient) Date

**Please make a copy of this release for your records**