Arizona Hand and Wrist Specialists

SURGERY OF THE HAND, WRIST, ELBOW AND MICROSCOPIC SURGERY

A Division of OSNA
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PERMISSION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I give my permission to Arizona Hand and Wrist Specialists and its medical staff to release protected health information to the following individuals.

Patient Name:_____

Patient DOB:_____

Patient Signature:_____

Date:_____

RELEASE INFORMATION TO:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

I understand that this authorization will expire two years from the date listed above.

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