

ORTHOPEDICS • SPORTS MEDICINE
ARTHROSCOPIC SURGERY
D. MATTHEW MADDOX, D.O., F.A.O.A.S.M., F.A.O.A.O.
SPORTS MEDICINE • ADULT RECONSTRUCTION • ORTHOPEDIC SURGERY
BRENT P. HANSEN, D.O.
EZEKIAS ZINK, PA-C
JENNIFER SPEER, PA-C

SPORTS MEDICINE • FAMILY MEDICINE
JOEL S. SELLERS, D.O., F.A.O.A.S.M.
NICOLE R. WALKER, PA-C

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request and consent that my medical records and non written records be sent to my referring physician, those physicians or ancillary facilities that I am referred to by the Creekside Corporate Center and to my insurance company or its agents that may be authorizing treatment. I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to the above.

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE (OR LEGAL GUARDIAN IF PATIENT IS A MINOR)

DATE

WITNESS

FINANCIAL AGREEMENT

I hereby authorize payment directly to the attending physician for medical and/or surgical benefits, if any, from the insurance carrier. If paying cash, I am responsible to pay at the time of service.

PATIENT'S SIGNATURE (OR LEGAL GUARDIAN IF PATIENT IS A MINOR)

DATE

WITNESS

CSMO-109 REV. 12/09

4344 W. Bell Road, #102
Glendale, AZ 85308-3589
(602) 588-4040
FAX (602) 588-4034