



Children's Orthopedic Specialists

THE ONLY PRACTICE DEDICATED TO PEDIATRIC ORTHOPEDICS
IN SOUTHERN ARIZONA

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Parent/Legal
Guardian Name: _____

I request and authorize Children Orthopedic Specialists to release healthcare information of the patient
named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:
- All healthcare information
- Other:

Parent/Legal
Guardian Signature: _____ Date: _____

Parent /Legal Guardian Printed Name: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED