SPINE DISORDERS OF ARIZONA, PC

Authorization / Request for Release of Medical Records

Practice closed effective September 1, 2026

Duane D. H. Pitt, MD - Records Custodian

Requests processed through Spine Disorders of Texas, PLLC | 1029 Long Prairie Road, Suite D, Flower Mound, TX 75022

Phone: 214-285-0987 | Fax: 214-513-4783 | spinedocaz.com

PATIENT INFORMATION

Last Name | First Name | MI | Date of Birth | Phone

Street Address | City | State | ZIP

Email Address

RECORDS REQUESTED

☐ Complete medical record **OR select specific records:** ☐ Office / consultation notes ☐ Operative reports

☐ Imaging reports ☐ Laboratory results ☐ Medication records ☐ Billing records ☐ Other:

Date range, if applicable - From | To | Do not include / exclude

WHERE SHOULD THE RECORDS BE SENT?

☐ To me, the patient ☐ To another healthcare provider, person, or organization

Recipient Name | Organization | Phone | Fax

Street Address | City | State | ZIP | Email

Delivery method: ☐ USPS Mail ☐ Fax ☐ Electronic delivery, if available ☐ Other:

PURPOSE OF REQUEST

☐ At my request ☐ Continuing medical care ☐ Insurance ☐ Legal ☐ Personal records ☐ Other:

AUTHORIZATION

I authorize Duane D. H. Pitt, MD, as Records Custodian for Spine Disorders of Arizona, PC, to release the health information identified above to the person or entity designated on this form. I understand that I may revoke this authorization at any time by written request, except to the extent action has already been taken in reliance on it; my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon signing this authorization; information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy law; and certain records may be subject to additional federal or state confidentiality requirements and will be released only as permitted by applicable law. I am entitled to receive a copy of this signed authorization. Unless I specify an earlier expiration date or event below, this authorization expires one year from the date I sign it.

Earlier expiration date or event, if desired:

SIGNATURE

Printed Name | Date | Patient Signature

Sign after printing, or use your PDF viewer's signing tool.

If signed by someone other than the patient:

Personal Representative Name | Relationship | Authority to Act for Patient | Date

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Submit completed form to:

Duane D. H. Pitt, MD, Records Custodian - c/o Spine Disorders of Texas, PLLC

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Please retain a copy of the completed authorization for your records. Revised 09/01/2026