

## Medical Records Request / Medical Records Release

Patient N	lame (print)			D.O.B		Acct #	
(i	initial) I authorize The Cen	ter for Spor	ts Orthopaedics P.C	to use or relea	ase/disclose my	health information as de	escribed
	initial) I authorize (name of p				to releas	e/disclose my health info	ormation as
described	d below to The Center fo	r Sports Oi	thopaedics P.C.	,			
Please re	lease <i>only</i> the following c	hecked info	rmation (check approp	oriate boxes and inc	lude other informat	tion where indicated) *Fee's l	May Apply *
	☐ Comple	te Copy of I	Medical Record		MRI Complet	ed in Office	
	☐ Last Off	ice Visit No	ote		MRI brought:	from other facility	
	☐ Lab Res	ults			Medication Li	ist / Allergy List	
	☐ X-Rays	Taken in O	ffice		Form Comple	tion	
	☐ X-Rays	brought fro	m other facility	,	Other:		
	tified information will be My Personal Records Sharing with other Health Other (please describe)				10100		_
Please in	itial each item below to in	dicate unde	rstanding.				
1	I understand the informati immunodeficiency syndro behavioral or mental healt	ome (AIDS) th services,	, or human immuno and treatment for al	deficiency virus cohol and drug	s (HIV). It may abuse.	also include information	1 about
	I understand once the info federal privacy laws or re		ow is released, it m	ay be re-disclos	ed by the recipi	ent, and may not be pro	ected by
1	I understand I have the rig writing and present my we to information that has all my insurance company w	ritten revoca eady been r	ation to The Center released in response	for Sports Ortho to this authoriz	opaedics. I unde ation. I understa	erstand the revocation will n	ill not apply
	I understand authorizing t treatment.	he use or re	lease of this informa	ation is voluntai	ry. I need not si	gn this form to ensure he	ealth care
The ident	tified information may be	used by or	released to the follo	wing individual	(s) or organizat	ions(s):	
Name:				Name:			
Address:				Address: _			
This auth If I fail to	norization will expire on the specify an expiration date or	ne (insert date	or event):uthorization will expin	re twelve (12) mo		te on which it was signed	
	Patient Signat	ure (or sig	nature of person co	ompleting form	n)	Date	
Relations	ship to Patient (circle one):	Patient	Legal Guardian	Other:			
Witness S	Signature	Da	te	Physician	Signature	Date	

Distribution of Copies: practice, patient accompany information released



## Medical Records Request / Form Completion Receipt

ne ( <i>print</i> ) D.O.B						
	<del></del> 1					
□ \$25 Patient Copy of Medical record						
\$15 Additional Copy MRI Disk (initial disk is free of charge)						
□ \$15 Additional Copy of X-Ray Disk (initial disk is free of charge)	)					
Form completion is charged out \$25 per form per diagnosis/disability period. Each additional form/diagnosis/disability period will be charged additionally.						
□ \$25 One Diagnosis/Disability/FMLA form completion						
□ \$20 Additional form completion						
For Office Use Only	For Office Use Only					
Diagnosis:						
Payment Received By: Staff Name Date						
Cash Check Credit Card						
of Request:						
Request Completed:						
Patient Notified of Completion:						
	\$25 Patient Copy of Medical record  \$15 Additional Copy MRI Disk (initial disk is free of charge)  \$15 Additional Copy of X-Ray Disk (initial disk is free of charge)  Form completion is charged out \$25 per form per diagnosis/disability period. Each additional form/diagnosis/disability period will be charged additionally.  \$25 One Diagnosis/Disability/FMLA form completion  \$20 Additional form completion  For Office Use Only  Charged Amount:  Payment Received By:  Staff Name Date  Cash Check					