



ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

Patient Medical Records Request Form

Patient Name (Print) SS or Health Record Number Patient DOB

I authorize to use or release/disclose my health information to Advanced Orthopaedics & Sports Medicine as described below.

I authorize Advanced Orthopaedics & Sports Medicine to use or release/disclose my health information as described below.

Please identify the information to be released:

- Please release/acquire my entire record -OR- Please release/acquire only the following information (check appropriate boxes and include other information where indicated): Problem list, Medication list, List of allergies, Immunization records, Most recent history, Most recent discharge summary, Lab results, X-ray and imaging reports, Consultation reports, Billing records, Other (please describe)

The identified information will be used for the following purpose:

- My personal records, Sharing with other health care providers as needed, Other (please describe)

Please initial each item below to indicate your understanding:

- I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s) (if applicable):

Name: Address: Name: Address:

This authorization will expire on or in twelve (12) months from the date on which it was signed)

Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: Parent Legal Guardian Other:

Witness Signature Date