Release of Medical Records

IMPACT ORTHOPAEDICS
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Medical Record Number_____

Patient Name_____Date of Birth_____

Address_____

City_____State_____Zip Code_____

Home Phone _____Mobile Phone _____Business Phone_____

Email Address_____

Recipient:

Clinic Name_____Phone_____Fax_____

Address_____

City_____State_____Zip Code_____

Dates of Service(s) Requested for Release: ☐ All dates ☐ Date Range: _____through_____

Information to Be Disclosed: *

- ☐ Office Visits
- ☐ Consultation Reports
- ☐ Radiology Reports/Images (X-Ray, CT, MRI, Ultrasound, etc.)
- ☐ Physical Therapy Reports
- ☐ Hospital Records, including Operative Reports
- ☐ All of the Above
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Other _____
- ☐ Worker's Compensation Reports

Reason for Release:

- ☐ Legal
- ☐ Out-of-Town Move
- ☐ Consult / Second Opinion
- ☐ Selected New Physician
- ☐ Insurance Claim Report
- ☐ Referred by Dr._____
- ☐ Insurance Changed to_____

Revocation: I understand that I may revoke this consent at any time and that the consent will automatically expire twelve months from the date of my signature. I do not authorize further release to a third party. I understand that once information is released under this authorization, clinic and their employees and my physician(s) cannot prevent the disclosure of that information.

Authorization: I authorize the above provider to release the information marked above to the recipient.

Patient / Parent / Guardian Signature _____Date Signed_____

Relationship to Patient (if Parent / Guardian)_____Reason Patient Unable to Sign_____

To Be Completed by Clinic Releasing Information

Date Records Copied_____Copied By_____

Medical Copies Were: ☐ Mailed ☐ Picked Up ☐ Faxed to_____