**MEDICAL RECORDS RELEASE FORM**

1) **PATIENT INFORMATION:**

______________________________________________________________________________________________

Name Address City State Zip

____________________________ (________)___________________________ __________________________________________________

Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

Specialty Orthopedics and Sports Medicine
Name of Medical Office

130 Crisanto Ave Fort Mill SC 29715 (803)-548-6464 (803)-396-8440
Address City State Zip Phone Number Fax Number

3a) **TO DISCLOSE TO:**

□ Self, Delivery Options: □Pick up □ Mail to home address

□To be picked up: I hereby authorize _______________________________________________________ to pick up my records**. (Photo ID required.)**

Send to: □ ______________________________________________________________________________________________

Name of Health Care Provider / Plan / Other

____________________________________________________________________________ _________________________________

Address Or Health Care Provider FAX #

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _________________ to _______________ **If left blank, only information from the past two (2) years will be disclosed.**
(month/year) (month/year)

5) **INFORMATION TO BE DISCLOSED:**

□All medical records related to (specify condition, treatment, etc.): _____________________________________________________________

□Radiology films/images (specify test): ________________________________________________________________________________

______________________________________________________________________________________________

6) **EXPIRATION:** This Authorization is good until the following date / event:
_____________________________________________________________ Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE:** (Check all that apply - **copy fees apply**) □Transfer of Care □Insurance Eligibility/Benefits □Personal (at my request)

□Other: _____________________________________________________________________________________________

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. **I understand that I may be charged a fee for record copies**. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying Specialty Orthopedics and Sports Medicine in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **PRINT/SIGNATURE OF PATIENT OR LEGAL REP**: ___________________________________________________ **DATE:** _______________

**If under 18, parent or legal guardian must sign.**

***For Office Use Only:***

Signature/ID verified □Yes □No Completed by: _________________________________________ Date released ______________ # of pages__________