SPECORTHO
Specialty Orthopaedics & Sports Medicine, LLC

CONSENT TO OBTAIN MEDICAL RECORDS

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

3b) **TO OBTAIN FROM:**

_____

Name of Health Care Provider / Plan / Other

_____ (_____)_____ (_____)_____

Address Phone Number Fax Number

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

5) **INFORMATION TO BE OBTAINED:**

□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_____