

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Physician _____
 Address _____
 Street _____ City _____ ST _____ Zip _____
 Birth Date _____ Social Security # _____ Phone # _____
 Maiden Name _____ Medical Record # _____

I hereby request and authorize the following institution to release my information:

Name _____ Phone # _____ Fax # _____
 Address _____
 Street _____ City _____ ST _____ Zip _____

Release to:

Name _____ Phone # _____ Fax # _____
 Address _____
 Street _____ City _____ ST _____ Zip _____

What information to send _____ A complete copy of the above-named patient's medical records, including all records relating to mental health, drug or alcohol-related condition, sexually transmitted disease or HIV status, if applicable.
 _____ Specifically, sent only _____

Reason records are being transferred _____

I understand that this consent can be revoked in writing at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I understand that consent will expire in 60 days.

Family Orthopaedics & Rehabilitation Center, LLC, its employees, and physicians are released from liability for the release of the above information to the extent indicated and authorized herein.

I understand that there may be a charge for copying of these records and/or films. A photocopy or facsimile of this authorization shall be as valid as the original.

 Patient Signature Date Witness Signature Date

By signing this consent, I affirm that I am 18 years or older. If I am under the age of 18, my parent or legal guardian gives consent for transfer of records, in this case, this person attests they are, in fact, the legal representative of the minor.

 Parent/Guardian Date Date Received by Medical Records

 Date Records Sent By