ORTHOPEDIC & SPORTS MEDICINE CENTER
OSMC

Authorization for Release of Medical Records

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Email: _____ MRN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Fax: _____

WHERE ARE THE RECORDS BEING RELEASED FROM?

Facility Name: _____ Provider Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

WHERE ARE WE SENDING THE RECORDS?

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

WHAT WOULD YOU LIKE RELEASED? CHECK ALL THAT APPLY.

❒ All Records ❒ Office/Clinic Notes ❒ Operative Reports
❒ Radiology Images ❒ Radiology Reports ❒ Labs
❒ Disability ❒ FMLA ❒ **Dates: _____ to _____**
❒ Other _____

PURPOSE OF DISCLOSURE: WHY ARE WE SENDING THE RECORDS?

❒ Continuation of Care ❒ Transfer to New Physician ❒Personal Use ❒ Attorney/Legal ❒ Insurance
❒ Disability ❒ FMLA ❒ Other: _____

DELIVERY METHOD: HOW WOULD YOU LIKE THE RECORDS SENT?

❒ Email ❒ Fax ❒ Portal ❒ Mail ❒ Pickup at OSMC (❒ Elk ❒ Gos ❒ Gra ❒ Mid ❒ Nap)
❒ CD ❒ USB ❒ Paper

PATIENT SIGNATURE

I hereby authorize OSMC to release or disclose to the person(s) or organization above, all medical records requested, including any specialty protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. **This authorization is valid for 60 days from the date of signature unless otherwise specified.** I understand that I may cancel this request with written notification but that it will not affect any information released priori to notification cancellation. I understand that the information used to or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient Signature: _____ Date: _____/_____/20_____

Relationship to Patient: _____ Expiration Date (60 days, if not specified) _____

❒ Patient was offered a copy ❒ Mailed ❒ Faxed ❒ Emailed ❒ Picked up Date: _____
❒ Patient or legal representative identity verified by picture ID.
❒ Form translated/Language: _____ Initials: _____

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