reno orthopedic clinic

MEDICAL RECORD
RELEASE OF INFORMATION AUTHORIZATION

WHO

Patient Name: _____ Date of Birth: ____/____/____ SSN #: (last 4) _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____-_____

FROM

I hereby authorize records FROM:

Name: _____ Address, City, State, Zip: _____

Phone:_____ Fax: _____

TO

To be released TO:

Physician Name/Facility/Self (Self for personal copies): _____

Address: _____

City, State, Zip: _____ Phone:_____

HOW

Delivery options: ☐ Pick-Up @ 555 N. Arlington Ave Reno NV 89503

☐ E-mail: _____

☐ Fax: _____ ☐ Mail ☐ CD (Radiology Images only)

Paper requests can take additional 3-5 business days for processing.

WHAT

Date of Service: From ___/___/____ To ___/___/____ ☐ All Dates of Service

☐Physician Office Note ☐Operative/Procedure Reports ☐Radiology/X-ray/MRI Reports

☐Lab/Path Reports ☐ Personal ☐ 2nd Opinion ☐ Other specified: _____ ☐ All

WHY

Purpose of Disclosure: (Please select one)

☐Referral to Specialist ☐Transfer of Care ☐Insurance ☐Workman's Comp ☐Legal Investigation

☐ Disability Determination/Claim ☐ Personal ☐ 2nd Opinion ☐ Other:_____

SIGNATURE

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

*This release expires one year from date signed unless I specify an expiration date: _____.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Name/Authorized Representative: _____

Patient Signature/Authorized Representative: _____ Date ____/____/____