reno orthopedic center

MEDICAL RECORD
RELEASE OF INFORMATION AUTHORIZATION

WHO

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

Address: _____ City, State, Zip: _____

Phone: (_____) _____-_____

FROM

I hereby authorize records FROM:

Reno Orthopedic Center
555 North Arlington Ave, Reno, NV 89503

Phone: (775) 786-3040
Fax: (775) 786-1358
Email: medrec@renoortho.com

TO

To be released TO: Physician Name/Facility Name/Self (your name):_____

Address: _____City, State, Zip: _____

Phone: (_____) _____-_____

HOW

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

☐ E-mail**:** _____ ☐ Fax: (_____) _____-_____ ☐ US Mail

WHAT

Date of Service: From_____ to_____

☐Physician Office Note ☐Operative/Procedure Reports ☐Radiology Reports ☐ Radiology CD (Images only)

☐ Billing Statement ☐ Other (specify): _____

SIGNATURE

Please initial each item below to indicate your understanding:

_____ 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.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

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 (Printed):_____

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

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