EL-AMIN
ORTHOPAEDIC & SPORTS MEDICINE INSTITUTE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT AUTHORIZATION

Complete this form to request release of medical records. Please print clearly or complete electronically.

1. PATIENT INFORMATION

Patient full name _____ **Date of birth** _____

Address _____

Phone _____ **Email** _____

2. RELEASE MY RECORDS TO

Name / organization _____

Address _____

Phone _____ **Fax** _____ **Email** _____

3. INFORMATION TO BE RELEASED

☐ Entire medical record (excluding specially protected records unless separately authorized)

☐ Office / clinic notes ☐ Imaging reports ☐ Operative reports ☐ Lab / test results

☐ Billing records ☐ Other: _____

Dates of service (optional): From _____ To _____

4. PURPOSE OF DISCLOSURE

☑ At my request ☐ Continuing care / second opinion ☐ Legal ☐ Insurance ☐ Other

5. EXPIRATION

This authorization expires upon completion of this records request unless I specify an earlier expiration date/event below.

Earlier expiration date/event (optional): _____

6. ACKNOWLEDGMENTS

I may revoke this authorization by written notice, except to the extent action has already been taken in reliance on it. Signing is not a condition of treatment or payment except where permitted by law. Redisclosed information may no longer be protected by federal privacy law. I may request a copy.

7. SIGNATURE

By typing my full legal name below and submitting this form, I intend it to serve as my electronic signature.

Electronic signature (type full legal name) _____ **Date** _____

Relationship / legal authority (if representative) _____