RELEASE OF MEDICAL RECORDS

PATIENT NAME: ______________________________ **Phone #:** (____) _______________ **Date of Birth:** ____/____/____
Address: _____________________________________ City: __________________ ST: ______ Zip: __________

I Authorize release of my medical records:

☐ **From Sports Medicine Institute**

Please send my records to:

Physician/Facility Name: ______________________________________
Address: ____
Telephone: (_____) ________________________ Fax Number: (_____) __________________

☐ **To Sports Medicine Institute**

From Physician/Facility: ____
Address: ____
Telephone: (_____) _____________________________ Fax Number: (_____) ______________________

Reason for release: ☐ Change of insurance ☐ Transfer of Care ☐ For my personal file ☐ Moving out of area ☐ Specialist consultation ☐ Legal

Records to Release: ☐ All records ☐ Recent H&P ☐ Lab Reports ☐ Hospital reports ☐ X-ray reports ☐ X-ray films ☐ Pharmacy/prescription reports ☐ Other: _______________________________________

- Please allow 15 days for processing
- Incomplete information will delay processing
- Use of this information for any other than the stated purpose is prohibited
- This information is for the use of the designated recipient only and cannot be provided to any other agency

CONSENT: I authorize the release of all information indicated and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol use. Also, be aware these records may contain information from previous providers.

☐ I authorize the release of HIV/HTLV/AIDS test results
☐ I understand that I may be charged for copies provided

____ ____/____/____
Signature of patient, parent or guardian Date

****Note*** This consent is valid for 90 days and may be revoked at any time*

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