

Shady Grove Orthopaedic Associates, P.A.

Authorization for Release of Medical Information

(PLEASE PRINT: Patient's Full Name)

Birth date (Month, Day, Year)

(Street Address)

Phone (Home/Daytime Number)

(City, State, Zip Code)

At the request of the individual, _____,

(Patient's Name or Parent/Guardian Name if patient is under the age of 18)

I do hereby authorize Shady Grove Orthopaedic Associates to release:

RECORDS ARE REQUESTED FOR THE FOLLOWING TIME PERIOD: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> EMERGENCY REPORTS |
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> LAB REPORTS | <input type="checkbox"/> DISCHARGE SUMMARY |
| <input type="checkbox"/> HISTORY & PHYSICAL | <input type="checkbox"/> RADIOLOGY WRITTEN REPORT | <input type="checkbox"/> DEXA SCAN REPORT |
| <input type="checkbox"/> OPERATIVE REPORTS | <input type="checkbox"/> EMG/NERVE CONDUCTION STUDY | <input type="checkbox"/> CD DISC OF X rays * |

*(There is a \$10 Fee for CD's)

PLEASE NOTE: RECORDS WILL NOT BE FORWARDED TO AN ATTORNEY BY FILLING OUT THIS FORM. ATTORNEY RECORD REQUESTS MUST BE MAILED/FAXED BY THE ATTORNEY'S OFFICE WITH THEIR SIGNED RELEASE & PREPAYMENT FEE REQUIRED. WE DO NOT KEEP RECORDS PAST 7 YEARS. RECORDS OVER 2 YEARS OLD USUALLY ARE IN STORAGE AND MAY REQUIRE UP TO 10 DAYS TO OBTAIN. RECORD REQUESTS ARE PROCESSED IN THE ORDER IN WHICH THEY ARE RECEIVED.

RELEASE MEDICAL INFORMATION TO:

SELF

Name of Company/Agency/Facility/Person

Street Address

City/State/Zip

PURPOSE OF DISCLOSURE:

PLEASE SPECIFY:

(Referral to Specialist/Other Doctor, Insurance, Legal Investigation, Etc.)

I hereby authorize disclosure of the health information for the above named patient. This AUTHORIZATION IS VALID for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

X _____
Signature of Individual or Guardian or personal Representative of Patient's estate (Power of Attorney must be on file with office or accompanying this request.)

DATE

NOTE: There will be a copying fee for your medical records of \$0.76 per page. This fee is in accordance with the rates set forth by the State of Maryland for copying and transfer of medical records. You will be notified by phone when the medical records have been reproduced. Payment of this fee will be required upon pick-up or if transfer of is made by mail or fax, this fee will be posted to your account accordingly.

*Safari Browser, Choose Print from File Menu