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Orthopedic Surgery
Specialized in Shoulder, Elbow and Knee Surgery
Adult Reconstruction
Sports Medicine
Trauma Surgery

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MEDICAL RECORDS REQUEST

Patient Name: _____ Date of Birth: _____
Social Security Number: _____
I authorize **Advantage Orthopedics** to release medical information to:
Name:
Address:
Phone:
Fax:
Reason for disclosure: _____
Dates of service requested: _____

Records to be disclosed:
____ All medical records from the medical care provided by _____
____EKG ____ Pathology Reports ____ Laboratory Reports
____ Operative Reports ____History and Physical ____ Radiology
____ Other (Describe) _____

I understand that if the person or entity that receives the requested information is not a health care provider or health plan covered by Federal privacy regulations, the information is not protected under Federal privacy regulations and May be disclosed to other persons or third parties by such person or entity. I acknowledge that I have the right to revoke this authorization at any time by submitting a written revocation except to the extent Advantage Orthopedics, Inc has taken action in reliance on the authorization. I acknowledge that Advantage Orthopedics, Inc. may not condition treatment on whether you sign this authorization, I further understand that the information in my health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human Immunodeficiency virus (HIV). My health record may also include information about behavioral health or mental health services and treatment for alcohol and drug abuse.

_____ Date: _____

Signature of Patient or Patient Representative

This authorization will expire 90 days from date of signature.

If a representative of the patient is signing the authorization, please state under what authority you are signing on the patient's behalf: _____