Medical Records Release Authorization

Upon presentation of this authorization you are requested to provide the records outlined below to: *(please print clearly)*

Send Records TO: Orthopedic Associates of Flower Mound and Denton
Person/Company Receiving Records

5000 Long Prairie Road, Suite 100
Address

Flower Mound | TX | 75028
City | State | Zip

(972) 420-1776 | **FAX to:** (214) 222-6660 | ***Attn:** Medical Records
Phone | Fax | To the attention of

Sending records FROM Clinic/Hospital: _____
Clinic/Hospital Name | Phone | Fax

Patient: _____
Patient Name | Phone | Date of Birth

Dates of Service (Check One and Complete Dates of Service if Required)

☐ Please provide a complete copy of my file for all dates of service

☐ Please provide a complete copy of my file for service from _____ through _____

Records to be Released (45 CFR § 164.508(c)(1)(i)).

Medical Records		Imaging	Itemized Billing
All Medical Records *Does not include Images or Billing*	History & Physical (Visit Notes)	Images on disk	Itemized Billing
Operative Report	Lab/Pathology Reports		
Radiology Reports	Other _____		

Purpose for Disclosure:

☐ Disability ☐ Insurance ☐ Attorney

☐ Referring Physician ☐ Patient Request ☐ Other (please state reason)

Other _____

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

Return to:
Orthopedic Associates - Medical Records
email: medicalrecords@orthoassociates.org
Medical Records fax: 214-222-6660

_____
Printed Name of Patient or Legally Authorized Representative