



Medical Records Release Form
Portions A-D must be completely filled out

A.) Date Information requested: ____/____/____

Name of Patient _____

Date of Birth _____ **SS#** _____ **Daytime Phone #** _____

Address _____ **Evening Phone #** _____

City _____ **State** _____ **Zip Code** _____

B.) Information to be released: (check all that apply)

From & To Dates _____

- Doctor's dictated notes with History & Physical only
- Operative Report(s) only
- Outside imaging report(s) only
- Lab Report(s) only
- Entire Medical Chart (all of the above)**
- Billing Ledger
- X-ray Films/Copies (**prepayment required**)
- Other _____

C.) Purpose of Disclosure:

- | | |
|--|--|
| <input type="checkbox"/> Changing Orthopaedic M.D. | <input type="checkbox"/> Second opinion (M.D. Name _____) |
| <input type="checkbox"/> PCP or Changing Primary Physician | <input type="checkbox"/> For Referred M.D. per Orthopaedic Specialists Dr. request |
| <input type="checkbox"/> Legal/Attorney | <input type="checkbox"/> Insurance/Disability Company |
| <input type="checkbox"/> For patient's own records | <input type="checkbox"/> School/Trainer |
| <input type="checkbox"/> Workers' Compensation | <input type="checkbox"/> Other _____ |

By signing this form, I understand that Orthopaedic Specialists, PLLC agrees to have my records available in 7-10 business days. However, I understand that the State of Kentucky Law allows 30 days for retrieval & 90 days for off-site retrieval. I also understand that I am entitled to one free copy of my medical records and I will be notified of a charge, if it applies, of \$.50/page. I may request my x-ray films to be copied at \$12/sheet. All fees are a prepayment. A signature must be obtained upon receipt of my records. I may receive a copy of this form if requested.

Patients Signature: _____

D.) Send accounting to:

- The address indicated above
- I will pick up the accounting in person. Please contact me at: _____ when the documents are ready.
- I request that another person other than myself pick up the records, _____ (name of person), and they must show I.D. **Patients Signature:** _____
- Please forward the accounting to another party, indicated below:

Signature of Attending Physician: _____

Date Request Filled ____/____/____ By: _____

Free Copy: Yes No Fee Requested: Yes No Date Fee Received: ____/____/____

Signature of Person in Receipt of Records: _____

Date: ____/____/____ Time: ____:____ am/pm

Signature of Associate releasing Records: _____