PLEASE PRINT

PATIENT INFORMATION
IF RECORDS EXCEED 25 PAGES, PLEASE MAIL RECORDS.

Name: ______________________________ Date of Birth: _____-_____-_____

Address: ______________________________

City: ____________________ State: ____________ Zip: ____________

Day/Work Phone #: ____________________ SSN #: ____________________

Type of Release Authorization:

☐ I authorize MAX Sports Medicine to **RELEASE** medical records to:

☐ I authorize MAX Sports Medicine to **OBTAIN** medical records from:

Name: ______________________________

Street: ______________________________

City: ____________________ State: ____________ Zip: ____________

Phone: ____________________ Fax: ____________________

Purpose of Request: ☐ Continue Care

☐ Other: ______________________________

Information Needed (include dates where appropriate and check all that apply):

☐ Lab results from date: ______________ to: ______________

☐ Radiology reports from date: ______________ to: ______________

☐ History & Physical from date: ______________ to: ______________

☐ Immunization Records

☐ Other: ______________________________

Authorization (Mandatory):

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation does not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition (no longer than 12 months):______________. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by the federal confidentiality laws.

Patient or Legal Representative's Signature: ______________________________ Date: ____________

Witness' Signature: ______________________________ Date: ____________

PLEASE NOTE NEW PHONE NUMBER

MEDICAL RECORDS RELEASE AUTHORIZATION

3705 Olentangy River Road, Suite 260
Columbus, OH 43214
Phone (614) 533-6600 • Fax (614) 533-6609

PATIENT IDENTIFICATION LABEL

3006749 (12/21/2012)