

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: _____



**MEDICAL RECORDS RELEASE
AUTHORIZATION**

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Dublin, OH 43016
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PATIENT IDENTIFICATION LABEL