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: _____

MAX SPORTS MEDICINE

MEDICAL RECORDS RELEASE AUTHORIZATION

300 Polaris Parkway, Suite 2150
Westerville, OH 43082
Phone (614) 533-3280 • Fax (614) 533-3289

PATIENT IDENTIFICATION LABEL