SOUTHERN OREGON Orthopedics
Our Specialty is YOU!

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Acct #:_____

Patient Name_____Birthdate_____

Current Address_____City_____St._____Zip_____

Home Phone_____(or) Cell Phone_____SS#_____

I AUTHORIZE INFORMATION:

To be released from:

_____
Name of Medical facility

_____
Name of physician

_____
Address

_____
City State/Zip Code

_____/_____
Phone # Fax #

Please send my records to:

_____
Facility or Patient Name

_____
Name of Physician

_____
Address

_____
City State/Zip Code

____
Phone # Fax #

TYPE OF INFORMATION TO BE RELEASED:

All items below____
Chart notes ____ Surgery Reports ____
Lab Reports ____ Pathology Report ____

What dates of service are needed?

From_____ to _____

XRAY CD YES NO
MRI CD YES NO

AUTHORIZATION TO RELEASE INFORMATION:

_____ DATE_____
Patient Signature

_____ DATE_____
Patient Representative & Relationship

PERMISSION TO FAX: YES_____NO_____

****This authorization is valid for one year and may be revoked by the patient (orally or in writing) at any time prior to one year****

OFFICE USE ONLY: Fax to: Patient_____Dr._____Other_____
Mail to: Patient_____Dr._____Other_____ Patient P/U____ Picked up date:_____Emp Int:___

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