PARAGON ORTHOPEDIC CENTER

702 SW Ramsey, Suite 112
Grants Pass, OR 97527
(541) 472-0603 Fax (541) 472-0609

MRN _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Print Name_____ Birthdate_____

Current Address_____City_____St_____Zip_____

Contact Phone_____

PATIENT TO PICK: *Yes ____ Date _____ Please call when ready _____*
MAIL TO PATIENT: *Yes ____*

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 Self

_____
Name of Physician

_____
Address

_____
City State/Zip Code

_____/_____
Phone # Fax #

TYPE OF INFORMATION TO BE RELEASED:

All items below ____
Chart notes _____
Lab Reports ____
Imaging Report ____ (MRI _____ EKG_____ Chest _____) **XRAY CD YES ____ NO** ____
Operative Report ____

WHAT DATES OF SERVICE ARE NEEDED?

From_____ to _____

AUTHORIZATION TO RELEASE INFORMATION:

_____ DATE_____
Patient Signature

_____ DATE_____
Patient Representative & Relationship

*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.

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OFFICE USE ONLY Released to: Patient _____ Dr. _____ Other _____
Mailed _____ Faxed _____ Patient P/U _____ Release date _____ Emp Inti: _____