



EAST ALABAMA ORTHOPAEDICS & SPORTS MEDICINE

Medical Records Release/Request Form

(Check One)

Release _____ Releasing information from us to you or your provider

Request _____ Requesting information from another provider to us

Date: _____

Name: _____ Phone: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ St: _____ Zip: _____

I authorize East Alabama Orthopaedics & Sports Medicine to **release/request** (*circle one*) the following:

Information Requested _____

To/From (*circle one*) Name: _____

Address: _____

City: _____ State _____ Zip: _____

Phone: _____ Fax: _____

(It is important that you give as much contact information as you can, especially the provider's name and phone.)

- I understand that this authorization shall be valid through _____ (*date*), but that I may revoke it **in writing** at any time: any such revocation shall have no effect on disclosures made previously. (*Valid for one year if not completed*)
- I understand that I have the right to inspect the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.

Signature _____ Date _____

Witnessed by _____ Date _____