SHADY GROVE ORTHOPAEDICS
SPECIALIZING IN WHAT MOVES YOU

Authorization for Release of Medical Information

Patient's Full Name (PLEASE PRINT) _____ Date of Birth (Month, Day, Year) _____

Street Address _____ Phone (Home/Daytime Number) _____

City, State, Zip Code _____

At the request of the individual, _____
(Patient's Name or Parent/Guardian Name **If Patient Is Under the Age of 18**)

I do hereby authorize Shady Grove Orthopaedics to release:
RECORDS ARE REQUESTED FOR THE FOLLOWING TIME PERIOD: _____

PLEASE CAREFULLY CHECK ALL THAT APPLY

____ ALL DR. APPT. RECORDS
(Does not include CD of X-Rays or physical therapy notes)

____ COPY OF BILL/LEDGER

____ EMERGENCY REPORTS

____ PHYSICAL THERAPY RECS.

____ LAB/PATHOLOGY REPORTS

____ DISCHARGE SUMMARY

____ HISTORY & PHYSICAL

____ RADIOLOGY WRITTEN REPORT

____ DEXA SCAN REPORT

____ OPERATIVE REPORTS

____ EMG/NERVE CONDUCTION STUDY

____ **CD DISC OF X-RAYS***
***(There is a $10 Fee for CD's)**

PLEASE NOTE: RECORDS WILL NOT BE FORWARDED TO AN ATTORNEY BY FILLING OUT THIS FORM. ATTORNEY RECORD REQUESTS MUST BE MAILED/FAXED BY THE ATTORNEY'S OFFICE WITH THEIR SIGNED RELEASE & PAYMENT FEE REQUIRED. WE DO NOT KEEP RECORDS PAST 7 YEARS. RECORDS OVER 2 YEARS OLD USUALLY ARE IN STORAGE AND MAY REQUIRE UP TO 10 DAYS TO OBTAIN. RECORD REQUESTS ARE PROCESSED IN THE ORDER IN WHICH THEY ARE RECEIVED.

RELEASE MEDICAL INFORMATION TO:

Name of Company/Agency/Facility/Person _____

____ **SELF**

Street Address _____

City/State/Zip _____

PURPOSE OF DISCLOSURE:
PLEASE SPECIFY: _____
(Referral to Specialist/Other Doctor, Insurance, Legal Investigation, Etc.)

I hereby authorize disclosure of the health information for the above named patient. This AUTHORIZATION IS VALID for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Individual or Guardian or Personal Representative of Patient's Estate (Power of Attorney must be on file with office or accompanying this request.) _____ Date _____

NOTE: There will be a copying fee for your medical records of $0.76 per page. This fee is in accordance with the rates set forth by the State of Maryland for copying and transfer of medical records. You will be notified by phone when the medical records have been produced. Payment of this fee will be required upon pick-up or if transfer is made by mail or fax, this fee will be posted to your account.

*Safari Browser, Choose Print from File Menu