SportsMED
Complete Orthopedic Care

4715 Whitesburg Drive ● Huntsville, AL 35802
Phone: 256-881-5151 ● Fax: 256-704-2397
medicalrecords@sportsmedlink.com

Authorization to Disclose Protected Health Information AND/OR Request for Medical Records from an Outside Facility

MEDICAL RECORD REQUESTS COULD TAKE UP TO 48 HOURS TO COMPLETE.

Patient Information

Patient Full Name: **Other Names Known By:**

Patient Address: **Date of Birth:**

City: **State:** **Zip:** **Phone #:**

Release Information:

Request for Records (Please Check One): ☐ **TO** ☐ **FROM**

Name/Facility: **Attention:**

Address: **Phone:**

City: **State:** **Zip:** **Fax #:**

Email: *(Please ensure email address is legible.)*

Purpose of Request (Please Circle): Personal Treatment Legal Insurance Transfer Other:

Please Forward Records by (Please Circle): Mail Fax* Email To be Picked Up

**Please note: We can only fax to continuing care facilities.*

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

☐ Please release a **1 year abstract** of my records (includes most recent notes, labs, procedures & testing)

☐ Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

☐ **Specific Date Range**:

☐ Progress Notes ☐ Radiology Reports ☐ Labs ☐ Operative Reports ☐ Injections
☐ Physical Therapy Notes ☐ Radiology Disk** ☐ Other:

Authorization to Release Protected Health Information:

I understand that:

1. The released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.
2. I may refuse to sign this authorization and that it is strictly voluntary.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.
6. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will automatically expire on the following date, event or condition: . *If I do not specify expiration this authorization will expire in 90 days.***

Please confirm that you have filled out this form in its entirety. If the form is incomplete, we may be unable to fulfill this request.

THE UNDERSIGNED AUTHORIZES TO RELEASE AND/OR REQUEST HEALTH INFORMATION.

Signature*: **Date:**

** For non-emancipated minors under the age of 19, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form. **Radiology Disk Fee for attorneys/insurance $15.00…for patients the first disc is free, additional is $5.00 each.*