Medical Records Release Form

<u>Portions A-D must be completely filled out</u>

Completed form may be faxed to (502)212-2004 or mailed to
4001 Kresge Way Ste 330
Louisville, KY 40207

A.) Date Information requested: _____/_____/_____

Name of Patient_____Date of Birth_____

SS#_____ Daytime Phone #_____

Address_____City_____ State _____ Zip Code _____

B.) Information to be released, which may include information concerning the treatment of drug/alcohol abuse, mental health and HIV/AIDS status (check all that apply)

From & To Dates _____

□ Doctor's dictated notes with History & Physical only
□ Operative Report(s) only
□ Outside imaging report(s) only
□ Lab Report(s) only
□ **Entire Medical Chart (all of the above)**
□ Billing Ledger
□ X-ray Films/Copies **(prepayment required)**
□ Other _____

C.) Purpose of Disclosure:

□ Changing Orthopaedic M.D.
□ PCP or Changing Primary Physician
□ Legal/Attorney
□ For patient's own records
□ Workers' Compensation
□ Second opinion (M.D. Name_____)
□ For Referred M.D. per Orthopaedic Specialists Dr. request
□ Insurance/Disability Company
□ School/Trainer
□ Other _____

By signing this form, I understand that Orthopaedic Specialists, PLLC agrees to have my records available in 7-10 business days. However, I understand that the State of Kentucky Law allows 30 days for retrieval & 90 days for off-site retrieval. I also understand that I am entitled to one free copy of my medical records and I will be notified of a charge, if it applies, of $.50/page. I may request my x-ray's to be copied at $12/CD. All fees are a prepayment. A signature must be obtained upon receipt of my records. I may receive a copy of this form if requested.

Patients Signature: _____

Witness _____

D.) Send accounting to:

□ The address indicated above
□ I will pick up the accounting in person. Please contact me at: _____ when the documents are ready.
□ I request that another person other than myself pick up the records, _____ (name of person), and they must show I.D. **Patients Signature: _____**
□ Please forward the accounting to another party, indicated below:

Signature of Attending Physician:_____

Date Request Filled _____/_____/_____ By:_____

Free Copy: Yes No Fee Requested: Yes No Date Fee Received:_____/_____/_____

Signature of Person in Receipt of Records: _____
Date: _____/_____/_____ Time: ____:_____am/pm
Signature of Associate releasing Records: _____