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 #**_____ **E-mail:** _____

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
- □ **Entire Medical Chart (all of the above)**
- □ X-ray Films/Copies **(prepayment required)**
- □ Billing Ledger
- □ Lab Report(s) only
- □ 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:** _____
- □ E-mail - I understand that unencrypted emails sent to me may contain protected health information, with attachments which are not secure and may be able to be viewed by others. I agree to hold harmless Orthopaedic Specialists, its officers, agents, employees, and contracted health providers from any and all liabilities, loss, damages, costs, or expenses which are sustained, incurred, or required arising from the transmission of unencrypted (unsecure) e-mail correspondence and attachments.
  Patients Signature: _____
- □ Please forward the accounting to another party, indicated below:

Signature of Attending Physician: _____ Free Copy: Yes No

Date Request Filled _____/_____/_____ By: _____ Fee Requested: Yes No

Date Fee Received: _____/_____/_____

Signature of Person in Receipt of Records: _____

Date: _____/_____/_____ Time: ____: _____am/pm

Signature of Associate releasing Records: _____

UPDATED 2/6/2023