

## **Medical Records Release Form**

\*Portions A-D must be completely filled out\*
Completed form may be faxed to (502)212-2004 or mailed to
4001 Kresge Way Ste 330 Louisville, KY 40207

Name of Patient		Date of Birth			_	
SS#_	Daytime Phone	e#E-		mail:		
Addı	ress	_City	State	Zip Code		
B.) In	oformation to be released, which may inclu	de information con	cerning the treatmen	nt of drug/alcohol abuse	, mental heal	th and
	AIDS status (check all that apply)		9		,	
	From & To Dates					
	From & To Dates Doctor's dictated notes with History & Pl	nysical only	□ Bil	ling Ledger		
	Operative Report(s) only		□ La	b Report(s) only		
	Outside imaging report(s) only					
	<b>Entire Medical Chart (all of the above)</b>					
	X-ray Films/Copies (prepayment requir	ed)	□ Otl	her	_	
C.) P	urpose of Disclosure:					
	Changing Orthopaedic M.D.	□ Second opinion	n (M.D. Name		)	
	PCP or Changing Primary Physician	□ For Referred N	I.D. per Orthopaedic S	Specialists Dr. request		
	Legal/Attorney	□ Insurance/Disa	bility Company			
	Degan i morney		•			
	For patient's own records					
	For patient's own records Workers' Compensation	□ Other				
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□ □ By sig I unde	For patient's own records Workers' Compensation gning this form, I understand that Orthopaedi erstand that the State of Kentucky Law allow	☐ Other c Specialists, PLLC s 30 days for retrieva	agrees to have my rec al & 90 days for off-si	te retrieval. I also unders	stand that I am	entitled
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**Signature of Associate releasing Records:** 

UPDATED 2/6/2023