Authorization Request for Release of Protected Health Information

(Outside Medical Records Release Form)

Please specify where we are requesting records from: ___________________________________ Fax: ____________________

I hereby authorize the use or disclosure of health information as described below for continued healthcare TO:

Southeast Orthopedic Specialists

Return Medical Records to Fax Number:

Requesting Physician: ____________________________________ Attention: __________________________________

Patient Name: ____________________________________ DOB: ______________________________

Social Security Number: _____________________________ Phone Number: ____________________________

Medical Records:

___Initial Patient Paperwork / Questionnaires
___Office Notes (Dates:___________________)
___Itemized Billing (Dates:________________)
___Physical Therapy Notes

Hospital Reports:

___Consult ___Operative Report
___History & Physical_____Discharge Summary

Diagnostic Imaging:

Body part of concern: ______________________________
___X-ray Films / Disc
___Laboratory Tests
___Diagnostic Reports (Type:________________)

Other: ______________________________
____
____

Patient/Parent/Guardian Signature:
____

Date:
____

Employee Signature:
____

Date: _______________