Methodist Sports Medicine
THE ORTHOPEDIC SPECIALISTS

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Main Phone: 317.817.1200
Medical Records Fax: 317.817.1240

# Medical Record Release Authorization
**Fax Completed Form To: 317.817.1240**

Patient Name: _____ Maiden Name: _____

DOB: _____

Home Phone: _____ Cell/Work Phone: _____

Address: _____ City/State/Zip: _____

Email Address: _____

**A) I hereby authorize records FROM:**

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

**B) To be released TO:**

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

**C) For the Purpose of:**

_____ Litigation
_____ Insurance
_____Self/Personal Copy
_____ Transfer or Continuity of Care
_____ Disability
_____Work Comp
_____ Other

Date Range: _____ To: _____

□Physician Office Notes
□Digital Images/X-Rays
□Operative/Procedure Reports
□Other _____
□Cardiology/EKG Reports
□Lab/Path Reports
□Radiology/X-Ray/MRI Reports
□Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

This authorization will expire one (1) year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

_____ _____
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

(Subject To Fees)

**PLEASE CHOOSE ONE: □Mail □Fax □Pick-Up: □Carmel □Greenwood □Bloomington**