MEDICAL RECORDS RELEASE

ORTHOPEDIC ASSOCIATES, PA
2300 E 30TH ST BLDG. D STE. 101
FARMINGTON, NM 87401
PHONE #: (505) 327-1400 FAX #: (505) 327-7875

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First set of records are at no charge. There is a $10 charge thereafter.

Patient Name	**Social Security Number**	**FYI PICK UP MAIL** **FAX:**_____
Address	**City/State/Zip Code**	
Phone Number:	**Cell Number:**	**Date of Birth:**

Due to HIPAA Regulations, *ALL SECTIONS MUST BE FILLED OUT COMPLETELY, or the medical records custodian will not accept them to be completed.* A signature and date are required. Failure to complete the form will result in a delay.

Records are to be released FROM: ☐ Orthopedic Associates ☐ Other facility / provider: Fill in below

Facility / Provider Name:_____

_____
Address City State Zip

_____ _____
Phone Number Fax Number

Records are to be released TO: ☐ Orthopedic Associates ☐ Other Facility or Person: Fill in below ☐ Self

2300 E 30th St
Bldg D Ste 101
Farmington, NM 87401

Facility or Person Name :_____

_____
Address City State Zip Code

_____ _____
Phone Number Fax Number

NOTE: Name of Disability Insurance or Insurance is not necessary if box is checked below

☐ **Disability** ☐ **Insurance** ☐ **Work Comp** ☐ **Attorney** ☐ **Another Medical Provider** ☐ **Work** ☐ **School**

What information do you need released? Body Part?_____

☐ **Complete Record** ☐ **X-ray reports** ☐ **X-ray CD/films** ☐ **MRI report** ☐ **MRI CD/ films** ☐ **Lab Results** ☐ **Billing Statement**

It is understood that the information released is for the purpose stated above and may not be provided in whole or in part to any other agency, organization or person. This information has been disclosed to you from records whose confidentiality is protected by State Law. State Law prohibits you from making further disclosure of such information without specific written consent of the person to whom the information pertains to; or as otherwise permitted by State Law. I understand I may revoke this authorization in writing at any time, exempt to the extent that action has been taken in reliance of this authorization. **NOTE: PATIENTS 18 YRS OLD ARE CONSIDERED ADULTS AND MUST SIGN FOR RECORDS.**

If the authorization has not been revoked, it will terminate one year from the date of my signature.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Relationship to Patient (Guardian, Parent, Power of Attorney) **Witness Signature**

Authorization for Disclosure to someone other than PATIENT, MINOR'S PARENT OR GUARDIAN

THE ABOVE INFORMATION MAY BE DISCLOSED TO:_____

ADDRESS:_____RELATIONSHIP:_____

CITY, STATE, ZIP CODE:_____PHONE #:_____