Release of Medical Records Form

Boyette Orthopedics
& Sports Medicine, PA

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Our Team: Working Together, Keeping You Active

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____
(Please circle preferred phone)

Email Address: _____

Dates of service requested for release: ◯ All dates ◯ Date range: _____ to _____

Information to be disclosed:

◯ Office Visits
◯ LaboratoryReports
◯ Radiology Reports
(X-Ray, CT, MRI, Ultrasound)
◯ Consultation Reports
◯ Physical Therapy Reports
◯ Workers Compensation
◯ Pathology Reports
◯ Hospital Records
◯ All of the Above

Clinic to which information should be sent:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Reason For Release: ◯ Legal ◯ Move ◯ Consult/Second Opinion ◯ Personal

Revocation. I understand I may revoke this consent at any time and that the consent will automatically expire one year from the date of my signature. I do not authorize release to a third party. I understand that once information is released under this authorization, Boyette Orthopedics & Sports Medicine, PA has no further control of said information.

Authorization. I authorize Boyette Orthopedics & Sports Medicine, P.A. to release the information marked above to the recipient.

Authorized Requestor Signature: _____ Date: _____

Please complete and mail this form to Boyette Orthopedics & Sports Medicine or fax to (252) 215-5201.

OFFICE USE ONLY

Date Records Copied: _____ Copied by: _____

Medical Copies sent via: ◯ Mail ◯ Patient Pickup ◯ Fax to: _____