# MEDICAL RECORDS REQUEST FORM

I, the undersigned, authorize _____

_____ to release my health information as noted below.

## PATIENT INFORMATION

***All sections must be completed in order for request to be processed***

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone #: (____)_____

Email Address: _____

## RELEASE INFORMATION TO:

| | | |
|---|---|---|
| ***APM SPINE AND SPORTS PHYSICIANS***<br>*5665 Lowery Road*<br>*Norfolk, Virginia 23502* | PHONE: 757-422-2966<br>FAX: 757-422-4563 | **ATTN:**<br>_____ |

Purpose of Request: ☐ Physical Therapy ☐ Procedure Pending ☐ Other/Reason: _____

## INFORMATION TO BE RELEASED

Please specify the information to be released:

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Notes ☐ Physical Therapy Notes ☐ Other: _____

Specify Dates of Service: _____

Body Part: _____

☐ **Entire Chart**

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**Required - *Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.*

| | | *Check One* | | *Initial each line below* |
|---|---|---|---|---|
| ☐ I DO | ☐ DO NOT | want information about | *Mental Health released | |
| ☐ I DO | ☐ DO NOT | want information about | *HIV Tests and Related information released | |
| ☐ I DO | ☐ DO NOT | want information about | *Alcohol and/or Substance Abuse released | |
| ****Other Sensitive Information**** | | | | |
| ☐ I DO | ☐ DO NOT | want information about | * | |
| ☐ I DO | ☐ DO NOT | want information about | * | |

STOP ***Please confirm that you have put a <u>checkmark and initialed</u> all of the protected categories above, regardless if they are applicable or not. If this form is incomplete, we may be unable to fulfill this request.***

- This authorization will expire one (1) year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the APM Spine and Sports in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation. _____**(Initials)**
- I understand that under the applicable law, the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard. _____ **(Initials)**

**Patient Signature:** _____ Date: _____

*(Required for all patients 18 years and older)*

**Signature of Parent or Legal Guardian** _____ Date: _____

*(Required for all patients under the age of 18 unless allowed by law. If not the parent, legal representation documentation must be supplied)*