



# SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

## Medical Records Release Form

### **PATIENT:**

Name: \_\_\_\_\_ DOB \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### **Release of Protected Health Information (PHI) - PATIENT AUTHORIZATION**

**I hereby authorize disclosure of my Health/Billing Information to the following individual:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Release of Medical Records - PATIENT AUTHORIZATION**

**I hereby authorize information in my medical records to be released and mailed to the address provided above.**

Date range to be released: \_\_\_\_\_ - or -

Specify exact information to be released: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***(Patient, Guardian or Authorized Representative)***

I understand there is a fee as outlined below:

Less than 10 pages – No Charge / Over 10 pages - \$0.42 per page to a maximum of \$50

Please charge my credit/debit card, I understand that the charge will not be specified until all work is completed and will not exceed \$50.

VISA \_\_\_\_\_ MASTERCARD \_\_\_\_\_ DISCOVER \_\_\_\_\_ AMEX \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Credit Card # \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Failure to fill out all sections will delay your request.*

*Allow up to 30 days for processing, as acceptable by law. \*Most requests completed within 10 business days.*

**Medical Records Services Provided By: Med Request Solutions Inc. 1 800-483-6040**