SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

Medical Records Release Form

PATIENT:

Name: _____ DOB _____ Phone: _____

Address: _____

Email: _____

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: Healthmark Group 1 800-659-4035