Request for Release of Medical Records/HIPAA Authorization

Patient Name:	DOB:
Street Address:	
City, State:	Zip:
Phone:	
Email:	SSN:
If this release is for a minor, please complete below:	
Name of Parent/Legal Guardian:	
Street Address:	
City, State:	Zip:
Phone:	
Email:	

HIPAA requires authorization to release medical records to anyone other than the patient. I hereby authorize the following healthcare professional, medical facility, family member, or legal representative (e.g. attorney) to receive:

- ❑ All my medical records from care I received at Sports Medicine & Orthopaedic Centers.
- ❑ My medical records as described here: _____
  _____

Name of Healthcare Provider, Facility or Representative:	
Street Address:	
City, State:	Zip:
Phone:	Fax:

Name: _____

Signature: _____ Date: _____