



Bone & Joint Specialists of Winchester, P.C.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

(please print)

PATIENT: _____ DATE: _____

ADDRESS: _____

PHONE: () _____ DATE OF BIRTH: _____

B&J Specialists Acct. No. _____ SOCIAL SECURITY #: _____

Records are to be obtained from:

Name of Doctor or Hospital: _____

Address: _____

Records are to be released to:

Name of Doctor or Hospital: _____

Address: _____

Records requested:

office notes pathology reports office x-rays
 operative notes x-ray reports other _____
 consultation reports discharge summary

Dates of Service: (from) _____ (to) _____

This section must be signed by the patient or legal guardian:

I understand that my record may contain sensitive information concerning use of controlled substances, HIV status, sexually transmitted disease, blood alcohol levels, psychiatric examinations or other medical information usually contained in a patient history. My signature indicates my authorization to release these records.

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will effect any information released prior to notification of cancellation. I understand the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Patient's Signature

Parent or Legal Guardian, if patient is a minor

Records Released on: _____ by: _____

Over 130 years of combined experience serving you.