

Plancher Orthopaedics & Sports Medicine

Medical Record Release

Last Name:

First Name:

Date of Birth

Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Doctors Reports | <input type="checkbox"/> CD containing all radiology images |
| <input type="checkbox"/> Operative Reports | (\$20.00 for CD) |
| <input type="checkbox"/> MRI Reports | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> CT Scan Reports | |
| <input type="checkbox"/> Xrays Reports | |
| <input type="checkbox"/> Ultra Sound Reports | |
| <input type="checkbox"/> Lab Reports
(.55¢ per page) | |
-

Please release medical records to:

Last, First Name:

Company Name:

Address:

Phone Number:

Medical records request will require a prepayment fee for copies. This authorization is good for 90 days from the date of signature. Photocopies and faxed copies of the form valid.

Signature: _____

Date: _____

PLEASE ALLOW 7-10 DAYS FOR PROCESS OF MEDICAL RECORDS