MPOC Orthopaedic Clinic

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J.D. Allen, M.D. Jeffery D Angel, M.D.
Dylan Carpenter, M.D.

Request for Medical Record Information

Name: _____ Date of Birth_____

Address: _____
City State Zip

I HEREBY authorize MPOC Orthopaedic Clinic to send or receive protected health information (PHI) about me to:

Name of Facility: _____

Address: _____
City State Zip

The information to be disclosed is:
___ History and Physical examinations
___ Consultation reports
___ Operative reports
___ Progress reports
___ Billing records
___ Discharge summaries
___ X-ray or MRI reports
___ X-ray or MRI disc
___ Other: _____

This information is being released for the following reason: _____

_____

Unless otherwise revoked, this authorization will expire one year from date of signature. I may revoke this authorization at any time, except where information has already been released. My written revocation must be submitted to Genice Hanson, Privacy Officer.

I understand that MPOC Orthopaedic Clinic may charge a fee for the costs of copying, mailing, or other supplies associated with this request.

_____ _____
Signature (Parent, Legal Guardian of minor child) Date

_____ _____
Print Name Relationship to patient giving representative authority to act for the patient

_____
Witness

Revised 10/3/16