

IRVING ORTHOPEDICS & SPORTS MEDICINE
2120 n. MacArthur Blvd. Ste. 100
Irving, Texas 75061
972-438-4636 Ext.: 1127

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____

Phone: () _____

I hereby authorize _____

To release to _____

Address: _____

The following medical, surgical, and radiology information on the above named patient:

- Progress Notes X- Ray Reports X- Ray Films
- MRI Films MRI Report DEXA Scan Report
- Billing Record Other

Dates of treatment: _____

Purpose for which this information is being released: _____

I understand that my records are protected under Federal Confidentiality Regulations Disclosure Act 42CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (i.e., probation, parole, etc.) and that in any event this consent expires automatically as described below.

This authorization will expire ninety (90) days from the date of my signature unless otherwise specified as follows:

Date

Signature of patient or legal representative

Date of Birth

Social Security Number

- Records are copied every Monday ready for pick up on Tuesday Mornings
- There will be a charge of \$25.00 for the set of medical records, 10.00 for MRI films per sheet, however a DICOM CD will be provided for no charge for physicians viewing only. (PAYMENT DUE UPON REQUEST)
- * ADDITIONAL CHARGE FOR MRI'S AND X-RAYS FILMS*(REVISED 01-01-05)