



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

1. I, _____, hereby authorize the Athletic Orthopedics and Knee Center to disclose the following specific medical information, by mail or fax, to:

Name: _____

Address: _____

2. Place your initials in the space(s) before the specific information you want released:

_____ Record of Clinic Visits

_____ X-Rays

_____ Statement of Charges and Payments

_____ Copies of outside reports which have been provided to Athletic Orthopedic and Knee Center by other medical providers (i.e., hospital records, lab tests, reports from consulting doctors)

_____ All of the above

_____ Other (Specify) _____

3. Records requested pertain specifically to my medical treatment beginning on _____

4. This information may be used for the specific purposes designated below, (Article 4495b, §5.08(j), Texas Revised Civil Statutes, **requires that an authorization for a release of medical records include "the reasons or purposes of the release"**)

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.

6. I understand that a photocopy of this authorization is valid as the original.

7. I understand that I may revoke this authorization at any time. In the absence of my prior revocation, this authorization will automatically expire in one year.

8. I understand that you will provide this information within fifteen (15) days of this request, and that a fee will be charged in the amount of \$25.00 for the first 20 pages, and .50 for each additional page along with the cost of postage, payable in advance. If X-Rays copies on cd are requested there is a \$8 fee for the cd.

Signature of Patient
(Or Guardian, if minor)

Date

Date of Birth
(For identification Purposes)