CORE ORTHOPEDICS & SPORTS MEDICINE

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PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____

DOB _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

I hereby authorize CORE Orthopedics to release information from my medical record as indicated below to:

☐ MYSELF *Or* ☐ _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

INFORMATION TO BE RELEASED

☐ PROGRESS NOTES Dates: _____

☐ X-RAY REPORTS Dates: _____

☐ X-RAY IMAGES Dates: _____

☐ OTHER: _____

- I understand that this authorization will expire one year after it has been signed.
- I understand that I may revoke this authorization at anytime by notifying the providing organization in writing, and it will be effective on the date notified except to the extent that the action has already taken in reliance upon it
- I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by the Federal privacy regulations.
- I understand that if I am being requested to release this information by _____ (Print name of Provider) for the purpose of: _____
    - By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
    - I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this after I sign it.
    - I have been informed that _____ (Print name of Provider) will not recieve financial or in-kind compensation in exchange for using or disclosing the health information described above.
    - I understand that in compliance with South Dakota statute, I will pay a fee of $42.40. There is no charge for medical records if copies are sent to facilities for ongoing care or follow-up treatment.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

X _____ Date _____