Authorization to Release Medical Record

Patient Name: _____ Date of Birth: ___/___/_____
Patient Address: _____ Phone: (____) _____-_____
City: _____ State: _____ Zip: _____

Information to disclose:

- ◘ Progress Notes
- ◘ X-ray Image CD
- ◘ X-ray/MRI/CT Report
- ◘ Lab Report
- ◘ Pathology Results
- ◘ Other: _____
- ◘ Diabetic Testing Results
- ◘ Doppler Results
- ◘ Operative Report
- ◘ History & Physical Report
- ◘ Entire Medical Record (All available)

For the period of:

- ◘ Last visit
- ◘ Last 3 visits
- ◘ Last 6 visits
- ◘ Last year to date
- ◘ All available
- ◘ Other: __/__/____

For the Purpose of:

- ◘ Continuation of Care
- ◘ Insurance Application / Insurance Claim
- ◘ Disability Determination
- ◘ Legal Investigation / Attorney
- ◘ Personal Record
- ◘ Other: _____

I authorize the release of the above information from:

Advanas Foot and Ankle Specialists
Address: 102 South Lakeview Avenue **City:** Sturgis **State:** MI **Zip:** 49091
Phone: 800-856-1106 **Fax:** 269-659-4704

To: Name/Facility: _____ ◘ Self
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: (____) _____-_____ **Fax:** (____) _____-_____

I would like my records to be:

- ◘ Faxed to: (____) _____-_____
- ◘ Copied to a USB **$20 .....**
- ◘ Copied to a CD (x-ray images only) **$10.....**
- ◘ Printed **$30.....**

***I understand that if there is a charge for copies, such charges must be paid prior to the release of copies.**

- ◘ picked up in office: - at my next appointment
  - call when ready
- ◘ mailed to the above address **$8.00**

This authorization is effective for 1 year unless stated otherwise: ____/____/_____. This authorization can be revoked in writing by the patient/responsible party at any time, but it is NOT retroactive to release of information made in good faith.

*By signing this authorization, the undersigned agrees **NOT** to disclose or make copies of indicated information, unless further disclosure is expressly permitted by necessary implication inherent in the purposes of the original consent or authorization. Proposed new use of information without additional written consent of the person to whom it pertains is prohibited. The undersigned hereby releases the above-mentioned institution from any liability which may arise from release and/or examination of the information indicated above.

Signature of Patient / Responsible Party: _____

Today's Date: ____/_____/_____

All patients are encouraged to use the Patient Portal to view visit summaries and dates of service.
Questions? Call 800-856-1106 or e-mail: inventory@advanas.com

For Advanas Staff Amount Collected: $_____ Date: ___/___/_____ Scanned by: _____