



## I AUTHORIZE VERO ORTHOPAEDICS TO RELEASE MEDICAL RECORDS INFORMATION

PROVIDE THE PATIEN		SE MEDICAL RECORDS IIVI	OTHER TOTAL		
Name:		Date of Birth:			
Email:		Phone:			
HOW WILL VERO ORT	HOPAEDICS RELEASE T	HE INFORMATION		(SELECT ONE OPTIO	
	ownload Records (1 – 2-c		☐ By Fax	(	
	s delivery, dependent up		·		
		e of \$15.00 and over 500 pag	ges will be charged a fee of \$		
	ORTHOPAEDICS WILL RI	ELEASE THE INFORMATION	I TO	(SELECT ONE OPTION)	
Clinic/Doctor's Name:  Send Email Link To:			☐ Fax To:		
☐ Mail To This Address					
City:	•	ST:	Zip Code:		
PROVIDE THIS INFORM	MATION ON THE RELEA	ASE:			
Dates of Service					
☐ Please provide a com	nplete copy of my file fo	or service <b>from</b>	through		
☐ Please provide a cop					
Records to be Release  ☐ All Medical Records			□ Padialogy Paparts	□ Dadiology Images	
☐ Medications	☐ Immunizations	<ul><li>□ Lab Reports</li><li>□ Operative Reports</li></ul>	<ul><li>□ Radiology Reports</li><li>□ Itemized Billing</li></ul>	☐ Radiology Images	
☐ Other		□ Operative Reports	in itemized billing		
Purpose for Disclosure					
☐ Continuing Care	☐ Transfer of Care	☐ Referring Physician	□ Disability		
☐ Legal/Attorney	☐ Insurance	☐ Patient Request	□ Other		
upon this authorization (4 O I understand that treat circumstances such as for employment purposes (45 O I understand that my repermitted by law. Informal longer protected. I understreatment of drug or alcol Acquired Immune Deficiel	y revoke this authorization of CFR § 164.508(c)(2)(i)). The ment or payment cannot participation in research of CFR § 164.508(c)(2)(ii)). The cords are confidential areation used or disclosed pustand that the specified in hol abuse, mental illness, ncy Syndrome (AIDS) (45.6)	be conditioned on my signing programs, or authorization of a cannot be disclosed withou rsuant to this authorization m formation to be released may or communicable disease, inc	this authorization, except in the release of testing results t my written authorization ex any be subject to redisclosure include, but is not limited to luding Human Immunodeficion	certain for pre- scept when otherwise by the recipient and no history, diagnosis, and/or ency Virus (HIV) and	
Signature:			Date:		
			Date		
Reason if patient is una	able to sign:				

(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)