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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Phone (541) 482-4533
Fax (541) 488-5102
www.ashlandortho.com

I authorize ASHLAND ORTHOPEDIC ASSOCIATES to release a copy of the medical information for

_____ _____
(Please print full legal name of patient) (Date of Birth)

to the patient or the patient's legal representative. The information will be used on my behalf for the following purpose(s):

___ Personal file ___ Insurance/Disability Claims ___ Continuity of Care

___ Attorney file ___ Other: _____

Please mark which medical records you wish released:

___ Office chart notes ___ Diagnostic reports ___ X-ray films ___ Billing statements

How would you like to receive your records?

___ Pick up When? _____

___ Mail to: _____

___ Fax to: _____

___ Email to: _____

_____ _____ _____
(Date) (Signature of patient or person authorized by law) (Phone Number)