ST • CROIX ORTHOPAEDICS
www.stcroixortho.com

Medical Records and X-ray Copy Request Release Authorization

Date: _____

PATIENT: _____ DOB: _____

NUMBER OF COPIES: _____

_____ Medical records

_____ All X-rays

_____ X-rays listed _____

Doctor _____

CD copies @ $11.00 each_____

TOTAL _____

DESTINATION: _____ Fax _____ Mailed

Address: _____

_____

_____

The information is requested to be released for the following purpose:

_____ Continued Medical Care

_____ Legal Claim Processing

_____ Other (Specify)

_____ Personal Interest

REQUESTED BY: _____ Patient _____ Other _____

INTERNAL REQUEST BY _____ **DATE:** _____ **TIME:** _____

COPIED BY: _____ **DATE:** _____ **TIME:** _____

My Medical Information may be obtained/exchanged verbally to: _____
(name & relationship to patient)

This authorization must be signed and dated, and may be revoked at any time according to St. Croix Orthopaedics, P.A. Notice of Privacy Practice except to the extent action has been taken prior to revocation. This consent will expire 365 days after the date below, or sooner by my choice, in which case this consent will expire on _____. I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the medical records to the purpose and extent stated above. Once these records are released, this information is not protected by St. Croix Orthopaedics, P.A. and may be potentially redisclosed by the party who received these records. I release St. Croix Orthopaedics, P.A. its employees, agents, directors, officers, and affiliates from any liability that may be incurred by giving this information to the above.

The undersigned acknowledges that there may be a charge for retrieval and copies of medical records and CDs of X-ray images.

_____ _____

Signature of Patient / Parent / Guardian Date