

DENALI ORTHOPEDIC SURGERY, PC  
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION  
MEDICAL RECORDS RELEASE

I authorize \_\_\_\_\_ to release health information on the patient listed below to  Self or  Other: \_\_\_\_\_.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart #: \_\_\_\_\_

The information is being requested for the following reason:

Personal copy of my treatment records                       Legal reasons \_\_\_\_\_  
 Continued care with another physician                       Other \_\_\_\_\_

**Please note there is no charge for the first copy of your paper records except for requests for complete chart copy. Copy fees will be assessed for additional copies and must be paid in advance. X-ray copies are \$11 per film and must be paid in advance.**

Please indicate the records requested below:

Limited records request. I am requesting only for a specific date or body part. My request is limited to \_\_\_\_\_  
 Records produced by Denali Orthopedic Surgery, PC. Dictations, x-ray reports and operative reports.  
 Complete chart copy which includes outside records, hospital and intake paperwork. Please contact me at \_\_\_\_\_ to provide a copy fee quote.  
 X-ray films- Specify body part: \_\_\_\_\_

Medical records are to be  Faxed to \_\_\_\_\_  Picked up by: \_\_\_\_\_  
 Mailed to \_\_\_\_\_

This authorization will automatically expire in six (6) months from the date signed. I understand that I may revoke this consent at any time and that revocation will not apply to information that has already been released as a result of this authorization. If I revoke this authorization, I must do so in writing and send it to the attention of the Medical Records Department. I understand that authorizing the disclosure of this health information is voluntary and that any disclosure of information carries with it the potential for an unauthorized redisclosure and may no longer be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of Patient/Guardian/Legal Representative                      Date                      ID Verification: Document and Number

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FOR DENALI ORTHOPEDIC SURGERY, PC USE ONLY

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Physician Authorization \_\_\_\_\_  
Initial and Date

Records copied by Employee Initials and Date: \_\_\_\_\_

Records:  Faxed  Mailed  Picked Up                      Employee Initials and Date: \_\_\_\_\_