

Name:
DOB:
Chart:
Age:
Date:

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Request for Release of Medical Records

As a patient of Southern Orthopaedic Surgeons, L.L.C. (SOS), you are entitled under federal law to access your personal medical records information. In order to process your request for access to this information, please complete this form. When received by medical records, they will use the information to verify your identity and process your request. If you have any questions or concerns, please contact our Medical Records department at: (334) 532-4636 or at P.O. Box 250450, Montgomery, AL 36125. You may also contact us via the Contact Us tab at www.sos-ortho.com.

Release To: Request From:

Provider or Entity

Phone

Address

City

State

Zip Code

Fax Number

Information Requested:

- Complete Medical Record
- Recent X-rays
- Labs

Purpose of Requested Use or Disclosure

- At the Request of the Individual
- Continues Medical Care
- Other: _____

Patient Name:

First M. Last

Date of Birth

First M. Last

Date of Birth

By signing this authorization, I authorize the use and disclosure of my Protected Health Information as requested. I understand that the information may be disclosed by the recipient and may no longer be protected by the federal HIPAA privacy rule. I understand that my rights are limited to any information in my "designated records set" as defined in Section 164.S01 of the Code of Federal Regulations.

Signature

Printed Name

Relationship to Patient

Address

City

State

Zip Code

Fax Number

Date of Authorization

Witness

This Authorization expires 90 days from Date of Authorization, or _____

Released By: _____