Active Orthopedics

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name_____
Address_____City_____
State____ Zip_____ Phone_____ DOB_____
Which records are needed: _____
Reason for transfer/request: _____

I, the undersigned, do hereby authorize and direct you to
[ ] Furnish records TO Active Orthopedics, LLC from:
[ ] Release records FROM Active Orthopedics, LLC to:

****IMPORTANT NOTICE: Per Active Orthopedics Policy, we only copy, print, mail or fax AO records. We do not copy, print, mail or fax other Doctor's medical records. Please contact your past Dr. for these records.

Name_____
Address_____City_____
State_____ Zip_____ Phone_____ Fax _____
Check how records are to be received: Mail _____, Pick-Up _____, Fax _____
(If all records are requested, AO will not fax records)
Active Orthopedics, LLC
6101 Webb Road, Suite 303 Tampa, FL 33614
Phone 813-885-5888 * Fax 813-885-5889

I understand that my request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I understand that I am responsible for the cost of copies. A copy of this authorization is as valid as an original and will expire 6 months from the date below.

Medical Records Request Fees:
 Print- I understand that you may charge me a fee of up to $15.00 if I request my entire chart for personal use.
 Oversized Document- I understand that you may charge me a fee of up to $25.00 if I request my entire chart for personal use and it exceeds 100 pages.
 NO CHARGE -Any Records that are to be released for the purpose of continuation of care to a designated physician or insurance company.

I UNDERSTAND THAT ACTIVE ORTHOPEDICS DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS.
PRINT NAME _____
SIGNATURE _____ Date: _____
WITNESS _____ Date:_____