

**REQUEST FOR RELEASE OF  
MEDICAL RECORDS – Date of Request \_\_\_\_\_**

Please make sure all blanks are filled in; failure to do so may prevent or delay of information.

*I hereby authorize Medical Records to be released to  
Ithaca Orthopaedic Group, PC  
10 Brentwood Drive, Suite B  
Ithaca, NY 14850*

**Patient Identification:** Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Maiden/Previous Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
 \_\_\_\_\_  
Phone #: \_\_\_\_\_

**Release of Medical Records FROM:** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
 \_\_\_\_\_

<b>Please Indicate</b> (Please initial all That apply)	<b>TO BE MAILED or</b>	<b>DATE TO BE PICKED UP</b>
	<b>Information Requested:</b>	<b>Date of Service:</b>
	Office notes:	
	X-Ray (Original or # of Copies )	
	MRI (Original or # of Copies )	
	Out of work/gym	
	Prescriptions	
	P.T. Scripts	
	Disability form	
	Other	

**If medical record contains any HIV/Psychotherapy information a separate release is required to be signed**

<b>Reason for Release:</b>	<b>Please Initial</b>	<b>Consult/Continued medical care</b>
		Legal
		Leaving the practice; please provide reasons or comments:
		Moving out of the area
		Dissatisfied with provider/staff
		Billing issues/concerns
		Wait time
		Other:
	<b>Comments:</b>	

Disclosure: I understand that this medical release may be revoked in by me, in writing, at anytime and that it will automatically expire 180 days after the date of signature. I understand that the recipient of this information may not use or disclose the medical information unless another medical release is obtained from me or unless such disclosure is specifically required or permitted by law. Ithaca Orthopaedic Group, PC is not authorized to disclose any medical information, which was obtained from other providers/facilities. A \$0.75 per page charge may apply.

Signature of Patient  
or Representative for release: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of Representative to patient: \_\_\_\_\_

Picked up by (Print) \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Verified by: \_\_\_\_\_

**For office use only:**  
# of pgs copied: \_\_\_\_\_ Date processed: \_\_\_\_\_ Staff signature: \_\_\_\_\_