



# Medical Records and X-ray Copy Request Release Authorization

Date: \_\_\_\_\_

PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

NUMBER OF COPIES: \_\_\_\_\_

\_\_\_\_ Medical records  
\_\_\_\_ All X-rays  
\_\_\_\_ X-rays listed \_\_\_\_\_

Doctor \_\_\_\_\_  
X-ray copies @ \$7.00/film \_\_\_\_\_  
\_\_\_\_\_ films @ \$7.00 = \_\_\_\_\_  
CD copies @ \$10.00 each \_\_\_\_\_  
Sales & Transit Tax \_\_\_\_\_  
TOTAL \_\_\_\_\_

DESTINATION: \_\_\_\_\_ Fax \_\_\_\_\_ Mailed \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_ Continued Medical Care \_\_\_\_\_ Personal Interest  
\_\_\_\_ Legal Claim Processing  
\_\_\_\_ Other (Specify) \_\_\_\_\_

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 rediscovered 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