



MEDICAL RECORDS REQUEST FORM

I, the undersigned, authorize _____
 _____ to release my health information as noted below.

PATIENT INFORMATION	***All sections must be completed in order for request to be processed***
Patient Full Name: _____ Other Names During Treatment? _____	
Patient Address: _____ Date of Birth: _____	
City: _____ State: _____ Zip: _____ Phone #: (____) _____	
Email Address: _____	

RELEASE INFORMATION TO:		
APM SPINE AND SPORTS PHYSICIANS 5665 Lowery Road Norfolk, Virginia 23502	PHONE: 757-422-2966 FAX: 757-422-4563	ATTN: _____
Purpose of Request: <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Procedure Pending <input type="checkbox"/> Other/Reason: _____		

INFORMATION TO BE RELEASED
Please specify the information to be released: <input type="checkbox"/> Office Notes <input type="checkbox"/> Labs <input type="checkbox"/> Operative Notes <input type="checkbox"/> Diagnostic Notes <input type="checkbox"/> Physical Therapy Notes <input type="checkbox"/> Other: _____ Specify Dates of Service: _____ Body Part: _____ <input type="checkbox"/> Entire Chart

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION	
**Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.	
<i>Check One</i>	<i>Initial each line below</i>
<input type="checkbox"/> I DO <input type="checkbox"/> DO NOT	want information about *Mental Health released
<input type="checkbox"/> I DO <input type="checkbox"/> DO NOT	want information about *HIV Tests and Related information released
<input type="checkbox"/> I DO <input type="checkbox"/> DO NOT	want information about *Alcohol and/or Substance Abuse released
****Other Sensitive Information****	
<input type="checkbox"/> I DO <input type="checkbox"/> DO NOT	want information about *
<input type="checkbox"/> I DO <input type="checkbox"/> DO NOT	want information about *

Please confirm that you have put a checkmark and initialed all of the protected categories above, regardless if they are applicable or not. If this form is incomplete, we may be unable to fulfill this request.

- This authorization will expire one (1) year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the APM Spine and Sports in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation. _____ **(Initials)**
- I understand that under the applicable law, the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard. _____ **(Initials)**

Patient Signature: _____ <i>(Required for all patients 18 years and older)</i>	Date: _____
Signature of Parent or Legal Guardian _____ <i>(Required for all patients under the age of 18 unless allowed by law. If not the parent, legal representation documentation must be supplied)</i>	Date: _____