CITRUS PARK SPORTS MEDICINE & ORTHOPAEDICS

6918 Gunn Hwy.
Tampa, Fl 33625
T: 813-855-8450 x. 5 F: 813-855-7540

Medical Records Release Authorization
In order to avoid a delay this form must be completed in its entirety.
PLEASE PRINT CLEARLY

Patient Name:____Maiden Name:________________________________

D.O.B. **(Required)**________________________________SS#**(Required)**______________________________

Home Phone:____Work Phone:__________________________________

Permission is hereby granted to Citrus Park Sports Medicine & Orthopaedics to release medical information to the individual/organization as noted below or to have records released to Citrus Park Sports Medicine and Orthopaedics:

☐ Mail to: Name:____

Address:____

City/State/Zip:____

☐ Fax to another medical entity (____)___________________________

☐ call when ready for pick up (____)____________________________

☐ Person picking up records

Please check information to be released:

☐ All records, excluding records from other physicians.
☐ Surgical Records
☐ Therapy reports
☐ Diagnostic test results
☐ Other____

☐ Office Notes only
☐ X-ray/MRI films
☐ X-ray/MRI reports
☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner.____
Date

I understand I have the right to refuse this authorization, in writing, and Citrus Park Sports Medicine and Orthopaedics is released from all legal liability that may arise from the released information requested.

____ ______________________________
Signature of patient/Legal Guardian Date