
**14 Thomas Point Road**
**Brunswick, ME 04011**
**Phone (207) 442-0325  Fax (207) 443-4578**

# MEDICAL RECORDS RELEASE/AUTHORIZATION

I hereby authorize and request Coastal Orthopedics & Sports Medicine to release to (place where records are going):_____

TEL:_____ FAX:_____

**(Note: If you are requesting your own records, and are going to pick them up please note that on the release; otherwise they will automatically be mailed to you)**

____ All of my medical records information including history, dates, course/summary of treatment received here

____ Statements I added to my medical records, with responses, if any

____ Only, (specify) _____

_____

This information may be used for:

____ Ongoing treatment/aftercare

____ Other: _____

**I understand that my express consent is required to release any health care information relating to testing, diagnostic and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric care, mental health or substance abuse of any kind. If I have been tested and/or treated for any of the above you are specifically authorized to release all health care information pertaining to such diagnosis, testing and/or treatment.**

Patient Name: _____ DOB: _____

Address: _____

_____

SSN (optional) _____

**I understand that I may revoke all or part of this authorization at any time by notifying this office in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation; I may refuse to disclose all or some of the information in my medical records; a refusal or revocation to release some or all information may result in improper diagnosis or treatment; I may have a copy of this form upon request; I may cross out any words on this form with which I disagree.**

Patients Signature _____ Date _____