Provider MR# Date:

EmergeOrtho

Record Request Form

AUTHORIZATION FOR REQUEST OF MEDICAL INFORMATION

Patient's Full Name: _____ Phone: _____

Street Address: _____ SSN#: _____MRN#_____

City/State/Zip: _____ ___Date of Birth: _____

I, the undersigned, authorize the entity named below to release my health information as noted to EmergeOrtho**, P.A.**

To process medical request form, please make sure you include phone and fax numbers. This will prevent delay in your request.

Request Information From

Name of Company/Agency/Facility: _____Attn: _____

Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

Information To Be Released/Requested

☐ Complete Record **OR** ☐ Partial Record** **Include:** ☐ X-rays ☐ MRIs

**Explain_____
(Indicate specific information needed and applicable date range if partial record is requested)

Authorize Release of Information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse. Yes___ No___

Signature: _____ Date: _____

Witness: _____ Date: _____

Authorization will expire 12 months from date of signature.

Fax To: 910-251-0421 or Mail To: 2716 Ashton Drive, Attn: MEDICAL RECORDS Wilmington, NC 28412