WRMC ORTHOPAEDIC & SPORTS MEDICINE CLINIC

501 Virginia Drive, Suite C, Batesville, Arkansas 72501

Phone: (870) 793-2371 • Fax: (870) 793-7585

Medical Records Release Form

Patient Name | Date of Birth | Patient Account Number

I hereby authorize:
WRMC Orthopaedic Clinic
501 Virginia Dr., Ste. C
Batesville, AR 72501

To release information to/receive information from:

_____

_____

_____

PURPOSE OF DISCLOSURE:

□ Continuing Care
□ Payment of Claim
□ School
□ Worker's Compensation
□ Legal
□ For Personal Use

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released unless you restrict by initialing below:

_____ Do not release Alcohol and/or Drug Abuse Information

_____ Do not release Behavioral Health Information

□ Other (specify content and dates): _____

INFORMATION TO BE RELEASED: Between Dates of: _____ to: _____

☐ Discharge Summary
☐ H&P Exam/Initial Evaluation
☐ Consult Notes
☐ X-Ray/MRI Reports
☐ X-Ray Films/MRI
☐ Diagnostic Test Reports
☐ Procedure Reports
☐ Lab Reports/Pathology
☐ Exchange of verbal communication
☐ Progress Notes/Provider Notes
☐ Psychiatric Testing
☐ Counselor/Therapist Reports
☐ Billing Records
☐ Other (specify content and dates): _____

ACKNOWLEDGMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is _____or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.
- I understand that WRMC Orthopaedic and Sports Medicine Clinic may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand I will receive a copy of this form after I have signed it, if requested.
- I understand that I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as the original.

Signature of Patient, Parent of Minor, or Personal Representative | Relationship | Date