RECORDS RELEASE

Orthopedic Associates of Cape Coral
657 Del Prado Blvd S Cape Coral FL 33990
PH (239)772-4484 FAX (844) 364-2545

Patient Name ____________________________________ Home Phone_____________
Address ____________________________________ Cell Phone ______________
City____________________ State _______ Zip_______ Work Phone _____________
Date of Birth ________________

Requesting Medical Records From:
Orthopedic Associates of Cape Coral
657 Del Prado Blvd S Cape Coral FL 33990
PH (239)772-4484 FAX (844) 364-2545

Please request at least 2 weeks in advance.
Please ___ Fax Records ___ Mail Records ___ Pt Pick Up

Records to be sent (please check those that apply):
__ Entire Record which includes, but not limited to the following:
__ Surgery Reports __ Pathology Reports and Biopsies
__ Progress Notes __ Ultrasound/Radiology Reports or films
__ Discharge Summary
__ Pap Smears __ Sexually Transmitted Disease Results Including
__ Laboratory work HIV or AIDS Testing
__ Psychological or Psychiatric Notes or Treatments
__ Substance Abuse Treatments
__ Records from any other treating or consulting physicians or nurses

Please Send My Medical Records To:

Name__________________________ Work Phone____________________
Address_________________________________ Fax______________________
City____________________________ State__________ Zip__________

I hereby authorize the disclosure of my medical information by Orthopedic Associates of Cape Coral. Unless specified below, this authorization will expire 6 months from the date signed below. I also understand copying charges of $1 per page up to 25 and then .25 cents per page thereafter plus postage may apply.

Signature___________________________ Date______________