RECORDS REQUEST

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:

Name _____ Work Phone _____
Address _____ Fax _____
City _____ State _____ Zip _____ Contact _____
Please request at least two weeks in advance.

Please ____ Fax Records ____ Mail Records

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:

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

This information is being disclosed for continued medical care. To revoke this authorization, I must do so in writing. This revocation does not apply to information already released. I hereby authorize the disclosure of my medical information to Dr Murray's practice. Unless specified below, this authorization will expire six months from the date signed below. I also understand copying charges of $1 per page up to twenty-five and then twenty-five cents per page thereafter plus postage.

Signature_____ Date_____