Thomas J. Parr, M.D., F.A.C.S.

Orthopedic Surgery and Sports Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Full Name _____Date of Birth: _____

I hereby authorize the office of **Thomas J. Parr, MD, PA** to disclose the information indicate below, either by U.S. mail, by e-mail (for electronic medical records - EMR), or by fax:

To: _____
(physician or treating facility)

Address:_____

_____

_____

Records from _____ to _____
(beginning date) *(ending date)*

(please initial if applicable)

_____Copies of Records of Clinic Visits

_____Copies of Records of Surgical Procedures and other Hospital or Outpatient Notes

_____Copies Outside Reports Provided By Other Providers (ie: Lab Test Reports, Imaging Reports, or Reports from Referring or Consulting Physicians)

_____Copies of X-rays taken in Dr. Parr's office

_____Other:_____

I am requesting this release for the purpose of:

_____Second opinion by another physician, Dr. _____ (***no charge***)

_____Insurance Company (***may be a charge***)

_____Disability Determination (***may be a charge***)

_____Attorney: Mr/Ms_____ (***charges will apply***)

_____Other:_____ (***charges will apply***)

1.) I understand that my records are confidential and cannot be disclosed without my authorization, except as otherwise provided by law.
2.) I understand that a photocopy or facsimile of this authorization is as valid as the original.
3.) I understand that I may revoke this authorization at any time. In the absence of my prior revocation, this authorization will automatically expire in one year from the date of signature.

_____ _____
(Patient's Signature) *(Parent's/Legal Guardian's Signature)*

_____ _____
(Date) *(Witness to Parent's/Legal Guardian's Signature)*

Dr. Parr is a limited liability partner in FOUNDATION SURGICAL HOSPITAL.

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