Athens Orthopedic Clinic
Orthopedic Consultant for The University of Georgia since 1966

1765 Old West Broad St.
Bldg 2, Suite 200
Athens, GA 30606
Telephone: (706) 549-1663
Fax: (706) 546-8792
www.athensorthopedicclinic.com

Medical Records Request

Patient Name: _____ Chart ID: _____

Date of Birth: _____ Phone #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Releasing records to another treating physician for continuation of care

Name of Provider/Practice/Facility: _____

Address: _____ City: _____ State: _____ Zip: _____

Fax #: _____ Phone #: _____ Email: _____

☐ Releasing records for personal use: _____Summary of Care ($6.50) _____X-Rays/CD ($10.00)
☐ Send via email ☐ Mail to address listed above ☐ Patient Pick Up ☐ Other _____

Records Requested: ☐ Entire Chart
☐ X-Ray/MRI
☐ Only specific information/specific time period: _____

The following types of records will be **excluded** unless specifically requested. Please specifically **include** records pertaining to:

_____Psychiatric Care _____Drug/Alcohol Abuse _____HIV/AIDS

This Authorization shall remain in effect until revoked by me in writing. If not revoked by me in writing, the Authorization shall remain in effect for one (1) year from the date of the signature below. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this Authorization Form. I understand that if I wish to revoke this Authorization, I must do so in writing and present my written revocation to Athens Orthopedic Clinic. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.

_____ _____ _____
Signature Date Relationship to Patient

When a representative of the patient signs this form, the representative must provide a description of such representative's authority to act for the patient: _____

Prepayment is required before record requests are processed. To make a payment please call 706-433-4010.

Payment Method: Cash _____ Check _____ Credit _____ Payment Received by: _____