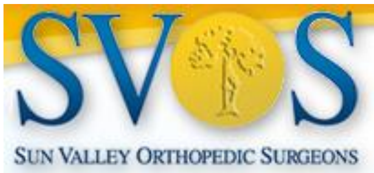

Martin G. Sterusky, MD
Robert C. Waldrip, MD
Lawrence J. Kelly, MD

Travis S. Jensen, DPM
Joseph M. Janzer, DO
Audrey K. Tsao, MD

MEDICAL RECORD RELEASE AUTHORIZATION

Patient Name: ______________________ DOB: ______________

Account #: __________ SVOS Physician: ______________

Requestor name if other than patient: ______________ Relationship to patient: ______________

SVOS Physician: ______________

I hereby authorize Sun Valley Orthopedic Surgeons to disclose the following Protected Health Information release of medical records **TO/FROM**:

Name of Person or Entity/Mail to Address:

____
Name

______________________ __________ __________
Address City State Zip Code

______________________ ______________________
Phone Fax

For the purpose of: ☐ Self ☐ Continuing Care ☐ Other ______________

Information Requested:

- ____ All Office Notes
- ____ Progress Note from ____/____/____
- ____ Other: ______________________
- ____ Radiology report from ____/____/____
- ____ Radiology CD from ____/____/____

Patient needs to contact facility where services were performed for operative reports or Bone Scans.

Additional Notes: ______________________

____

I understand this authorization covers records relating to

__________ ______________________ ______________
Date Patient Signature or Legal Representative Relationship to Patient

______________________ ______________________
ID verified by (SVOS Staff) Date

Documented in Aprima: ______________
Records were: Mailed / Faxed / Other
Completed by: ______________
Date Completed: ______________