Hand and Microsurgery Associates

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MEDICAL RECORD REQUEST

Patient Name _____Date of Birth: _____/_____/_____
Social Security Number: _____

I Authorize _____to release medical information to:

Hand and Microsurgery Associates, Inc.
1210 Gemini Place Suite 200
Columbus, OH 43240

Reason for disclosure: _____
Dates of service requested: _____
Reports to be disclosed:

☐ EKG ☐ Laboratory Report ☐ Pathology Reports
☐ History & Physical ☐ Operative Reports ☐ Radiology
☐ Other:_____

I understand that if the person or entity that receives the requested information is not a health care provider or health plan covered by Federal privacy regulations, the information is not protected under Federal privacy regulations and may be disclosed to other persons or third parties by such person or entity.

I further understand that the information in my health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ Date: _____
Signature of Patient or Patient's Representative

This authorization will expire 90 days from date of signature.

If a representative of the patient is signing the authorization, please state under what authority you are signing on the patient's behalf:_____