Orthopedic & SportsMedicine
Clinic of Fairbanks
2310 Peger Rd. Ste 105, Fairbanks, AK 99709
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# CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Orthopedic & Sportsmedicine Clinic of Fairbanks to:

Release information to*:_____ Obtain information from*:_____

Provider/Clinic:_____

Address:_____

City/State/Zip:_____

Phone #:_____ Fax #:_____

**Purpose of Information:**

_____ Second Opinion
_____ Continue Treatment
_____ Personal Use
_____ Legal Use

**Information Requested:**

_____ Progress/Chart Notes
_____ Operative Notes
_____ X-ray Images- *can't be faxed*
Date(s): _____ to _____

Patient Name:_____ Phone #:_____

Date of Birth:_____ SSN: (optional)_____

Address:_____

City/State/Zip:_____

Signature:_____ Date filled out:_____

Would you like it: ____ Faxed* ____ Mailed*
____ PT Pick up Date picked up:_____ Signature:_____

**IF PICKING UP RECORDS, YOU WILL RECEIVE A PHONE CALL WHEN YOUR RECORDS ARE READY. BY LAW, FULFILLMENT OF MEDICAL RECORDS REQUEST IS 30 DAYS FROM DATE REQUESTED.**

*****If you are requesting records to be mailed or faxed, please provide the address and fax number where you would like your records sent.

**First copy of medical records and digital x-rays are at no charge. Any additional copies of medical records are $25.00 and x-rays are $15.00.**