



MARK WADE M.D. | NEAL EVERSON D.O. | MATTHEW BURNHAM M.D.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Orthopedic & Sportsmedicine Clinic of Fairbanks to:

☐ Release information to* ☐ Obtain information from* ☐ Self

Provider/Clinic: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Fax #: _____

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

Purpose of Information

- ☐ Second Opinion
- ☐ Continue Treatment
- ☐ Personal Use
- ☐ Legal Use

Information Requested

Joint / body part: _____

☐ Progress/Chart Notes ☐ Operative Notes

☐ X-ray Images - **mail or pickup only**

Date range: _____ to _____

Patient Information

Patient Name: _____ Phone #: _____

Date of Birth: _____ SSN (optional): _____

Address: _____

City/State/Zip: _____

Delivery / Pickup

Would you like it: ☐ Faxed* ☐ Mailed* ☐ PT Pick up

Date filled out: _____ Signature: _____

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 requests is 30 days from the date requested.

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.

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