



ALABAMA ORTHOPAEDIC
SPECIALISTS, P.A.

4294 Lomac Street (36106)

Post Office Box 235003 • Montgomery, Alabama 36123-5003

www.aosonline.net

REQUEST FOR RELEASE OF MEDICAL RECORDS

As a patient of Alabama Orthopaedic Specialists, P.A. (AOS), you are entitled under federal law to access your personal medical records information. In order to process your request for access to this information, please complete this form. When received by medical records, they will use the information to verify your identity and process your request. If you have any questions or concerns, please contact the Privacy Officer or Practice Administrator: P.O. 235003 Montgomery, AL 36123-5003.

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____

Chart Number: _____ Date of Request: _____

I understand I have the right to view my medical records information and obtain a copy of the information,

I would like a copy of my medical records. This is to include my x-rays YES No. The purpose of the copy is:
{Please check one} personal use insurance school legal social security/disability.

I authorize the release of my medical records to:

I understand that I will be charged a fee for the copies as set forth in the following schedule: \$5.00 for research and retrieval, \$1.00 per page for the first 25 pages, and \$.50 per page for each additional page. Copies of x-rays are \$5.00 per sheet. I understand AOS utilizes an outside copy service for this purpose and I will receive a bill along with the records from this firm. Copies of x-rays will be billed to me by AOS

I would like AOS to send the copy via U.S. mail to the following address:

I understand that AOS may charge me all applicable postage fees.

AOS will normally process medical records release request within 10 working days, unless the chart is stored off site.

I understand that AOS is given **thirty days** to process my request for access if my information is maintained on-site, **sixty days** if the information is maintained off site, and that AOS may extend the deadline by an additional thirty days if I am notified in writing of the extension. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

By signing below, I acknowledge and agree to the above conditions and payment of copy fees.

Signature of Patient

Date

OFFICE USE ONLY BELOW THIS LINE

Patient's Physician

Copies have been paid for: _____ YES _____ NO

Do you approve of this record release? _____ YES _____ NO

AUTHORIZING PHYSICIAN'S SIGNATURE