A·O·S
ALABAMA ORTHOPAEDIC SPECIALISTS, P.A.
4294 Lomac Street • Montgomery, Alabama 36123-5003
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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 consult the Privacy Officer or Practice Administrator; P.O. 235003 Montgomery, AL 36123-5003.

PATIENT INFORMATION

Patient Name:

Chart Number:

I understand that 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 $0.50 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 requests 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