



Dr. Thomas J Kovack, D.O

President and CEO

Orthopedic Surgery

Specialized in Shoulder, Elbow and Knee Surgery

Adult Reconstruction

Sports Medicine

Trauma Surgery

103 Commerce Park Drive Suite A

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MEDICAL RECORDS REQUEST

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

I authorize _____ to release medical information to:

Name: **Advantage Orthopedics**

Address: **103 Commerce Park Drive Suite A Westerville, OH 43081**

Reason for disclosure: _____

Dates of service requested: _____

Records to be disclosed:

____ All medical records from the medical care provided by _____

____ EKG ____ Pathology Reports ____ Laboratory Reports

____ Operative Reports ____ History and Physical ____ Radiology

____ Other (Describe) _____

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 acknowledge that I have the right to revoke this authorization at any time by submitting a written revocation except to the extent Advantage Orthopedics, Inc has taken action in reliance on the authorization. I acknowledge that Advantage Orthopedics, Inc. may not condition treatment on whether you sign this authorization, 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 health or mental health services and treatment for alcohol and drug abuse.

Signature of Patient or Patient Representative

Date: _____

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: _____