Peter S. Birnbaum D.O
Orthopaedic Surgery, Sports Medicine, Hand & Microvascular Surgery

Medical Records Release/Request Form

(*Check One*)
Release _____ Releasing information from us to you or your provider
Request _____ Requesting information from another provider to us

Date:_____
Name:_____ Date of Birth:_____
Address:_____
Phone:_____ Social Security #_____

I authorize Dr. Peter S. Birnbaum D.O. to **release/request** (*circle one*) the following:
Information Requested_____
_____

Purpose of Request_____

To/From (*circle one*) Name_____
Address_____
Phone and Fax:_____

(It is important that you give as much contact information as you can, especially the provider's name and phone.)

• I understand that this authorization shall be valid through_____ (date), but that I may revoke it **in writing** at any time; any such revocation shall have no effect on disclosures made previously.
• I understand that I have the right to inspect and copy the information to be released.
• I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
• I understand that the release of information may **not** be re-released to any other person or organization without my written consent.

If you are picking up for the patient please state your relationship: _____

Signature_____ Date_____

(Office use only)

Witnessed by _____ *Date* _____

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