43475 Dalcoma Dr., Suite 250
Clinton Township, MI 48038
Phone: (586) 436-3785 | Fax: (833) 972-5451

Medical Records Release

Patient Information

Patient Name: ______________________________ **DOB:** __________________

Address: ____

Phone: __________________ **SSN (last 4):** ____________

Release Records From

Facility / Provider Name: ____

Address: ____

Phone: __________________ **Fax:** __________________

Send Records To

Movement Orthopedics, PLLC

43475 Dalcoma Dr., Suite 250, Clinton Township, MI 48038

Phone: (586) 436-3785 | Fax: (833) 972-5451

Records Requested

☐ All medical records related to: ____

☐ Office/Clinic notes Date range: __________________ to __________________

☐ Operative reports ☐ Pathology reports ☐ Lab results

☐ Diagnostic imaging (X-ray, MRI, CT) ☐ Physical therapy notes

☐ Emergency department records ☐ Discharge summary

☐ Other: ______________________________

Purpose

☐ Workers' compensation ☐ Continuing care ☐ Legal ☐ Insurance ☐ Personal request

Authorization

I authorize the above-named facility/provider to release the specified medical records to Movement Orthopedics, PLLC. I understand this authorization is voluntary and I may revoke it in writing at any time, except to the extent that action has already been taken. This authorization expires 90 days from the date signed unless otherwise specified.

____ ____

Patient Signature (or Legal Representative) Date

Printed Name: ______________________________