

1. PATIENT

Patient full name _____ Date of birth _____ Phone _____ Other names used (optional) _____

Address, city, state, ZIP _____

2. RELEASE RECORDS FROM (provider / facility currently holding the records)

Provider or facility name _____ Phone _____ Fax _____

Address, city, state, ZIP _____

3. RELEASE RECORDS TO

Andrew P. Dold, MD - Star Orthopedics and Sports Medicine, 6700 Dallas Parkway, Suite 100, Frisco, TX 75034 | Phone 469-850-0680 | Fax 469-850-0681

4. INFORMATION TO BE RELEASED

☐ Office / clinic notes ☐ Operative reports ☐ Imaging reports (X-ray, MRI, CT) ☐ Imaging studies (images / disc)

☐ Physical therapy notes ☐ Lab results ☐ Hospital / ER records ☐ Other: _____

Dates of service (from - to), or "all" _____

Body part / condition (optional) _____

5. PURPOSE

☐ Continuity of care / treatment ☐ Second opinion ☐ At my request ☐ Other: _____

6. SENSITIVE INFORMATION (initial if you AUTHORIZE release of any of the following, if contained in the records)

☐ ___ HIV/AIDS ☐ ___ Mental health ☐ ___ Substance use treatment ☐ ___ Genetic testing

Records of substance use disorder treatment protected by federal law (42 CFR Part 2) require separate, specific consent and are not released under this form unless you initial above and the holding program's requirements are met.

7. EXPIRATION, RIGHTS AND SIGNATURE

This authorization expires on the date or event written here: _____ (if left blank, it expires one year from the date signed).

I understand that: (1) I may revoke this authorization at any time by sending a written request to the provider releasing the records, except to the extent action has already been taken in reliance on it; (2) my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization; (3) information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations; (4) I may refuse to sign this authorization; and (5) I am entitled to a copy of this signed form. A copy or fax of this authorization is as valid as the original.

Signature of patient or legal representative _____

Printed name _____

Date _____

If signed by a representative: relationship / legal authority to act for patient _____

Phone _____

Please fax or bring this form to our office, or send it directly to the provider holding your records. For questions, call 469-850-0680.