Chart#: _____

Klamath Orthopedic & Sports Medicine Clinic

2200 Bryant Williams Drive Suite 1 Klamath Falls, OR 97603 Phone 541-884-7746 Fax 541-274-5705

Request to disclose medical records, per ORS 192.525

Patient Name: _____

Date of Birth: _____

Last four digits of ssn: _____

Fax and phone number: _____

Recipient and address: _____

Reason for request: _____

I am requesting medical records specifically related to: _____ date: _____.
(body part) (service date)

*Office Notes*_____ *MRI CD or Report*_____ *Financial Statement*_____ *Operative Report*_____

*Our practice is to provide two years of studies for X-Ray CD*_____ *Comments:* _____

I understand Klamath Orthopedic & Sports Medicine Clinic will provide the first set of records at no cost to me. After which, I agree to pay for duplicate copies at .25 cents per page. I further understand all records for the purpose of providing documentation to attorneys are to be requested, billed and pre-paid by the attorney.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol or drug abuse.

I understand that I have the right to revoke this authorization at any time; if I revoke this authorization I must do so in writing.

I understand I may to refuse to sign this authorization. I need not sign this authorization in order to ensure treatment.

This authorization pertains to records for dates on or prior to my signed records request and a new records request is necessary for future records.

This authorization must be dated and signed by the patient or by a person authorized by law to give authorization.

_____

Signature of patient/legal representative Relationship Date

Mail to address provided: _____ Fax to the number provided: _____

Revised 3-10-17