AUTHORIZATION TO RELEASE MEDICAL RECORDS TO REBOUND ORTHOPEDICS & NEUROSURGERY

Patient Name: ______________________________ Date: ______________

Maiden Name: ______________________________ Social Sec. No.: ______________

Date of Birth: _____ / _____ / _______
Month Day Year

I Authorize My Medical Records to Be Released From:

Doctor Name: ______________________ Address: ______________________

Clinic Name: ______________________ ______________________

Phone #: (____) ______________________ City: ______________________

Fax #: (____) ______________________ State: ________ ZIP: ____________

Purpose of Disclosure: ❒ Referral/Continuation of Care ❒ Other: ______________________

Release My Medical Records to:

Rebound Orthopedics & Neurosurgery
200 NE Mother Joseph Place, Suite 210
Vancouver, WA 98664
Phone #: (360) 449-1141
Fax #: (360) 449-1146

Please Provide the Following Records:

- ❒ Complete Medical Record
- ❒ Diagnostic Images
- ❒ Diagnostic Reports
- ❒ Notes Related to a Specific Body Part: ____________
- ❒ Patient Demographics & Insurance Information (Needed for Patient Referrals)

I This authorization ends on (date) ______________________ (if not specified, expires 90 days from date signed).

I understand I do not have to sign this authorization in order to receive healthcare or benefits, except to participate in a research study or create healthcare information for a third party. I understand that I may revoke this authorization by submitting a written request. The revocation would not affect any actions taken prior to notification of revocation, and I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand the information released may be subject to re-disclosure by the person or class of persons or facility receiving it and that privacy laws may no longer protect it.

I further authorize the release of healthcare information regarding testing, diagnosis and/or treatment for:
❒HIV (AIDS Virus) ❒Psychiatric Disorders/Mental Health ❒Sexually Transmitted Diseases ❒Drug and/or Alcohol Use

Signed: ______________________________________ Date: ______________
Patient or Legally Authorized Individual

If Signed on Behalf of the Patient: Print Your Name: ______________________________

Describe Your Authority to Act on Behalf of the Patient:
❒ Parent or Legal Guardian (If Patient Is a Minor) ❒ Durable Power of Attorney for Healthcare
❒ Court-Appointed Personal Representative ❒ Other: ______________________

Witness: ______________________________________ Date: ______________

A Division of Northwest Surgical Specialists, P.C.
200 NE Mother Joseph Place, Suite 210, Vancouver, WA 98664
Phone: (360) 254-6161
Fax: (360) 449-1146
www.reboundmd.com

The Region's Most Preferred.

Rebound Orthopedics & Neurosurgery complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.