MAJOR
Sports Medicine

275 WEST BASSET ROAD, SUITE 3, SHELBYVILLE, INDIANA 46176 • 317-421-3265 / FAX 317-398-1872

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Physician _____
Address _____
Street _____ City _____ ST _____ Zip _____
Birth Date _____ Social Security # _____ Phone # _____
Maiden Name _____ Medical Record # _____

I hereby request and authorize the following institution to release my information:

Name _____ Phone # _____ Fax # _____
Address _____
Street City ST Zip

Release to:

Name _____ Phone # _____ Fax # _____
Address _____
Street City ST Zip

What information to send_____ A complete copy of the above-named patient's medical records, including all records relating to mental health, drug or alcohol-related condition, sexually transmitted disease or HIV status, if applicable.

_____ Specifically, sent only _____

Reason records are being transferred _____

I understand that this consent can be revoked in writing at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I understand that consent will expire in 60 days.

Major Sports Medicine, its employees, and physicians are released from liability for the release of the above information to the extent indicated and authorized herein.

I understand that there may be a charge for copying of these records and/or films. A photocopy or facsimile of this authorization shall be as valid as the original.

_____ _____ _____ _____
Patient Signature Date Witness Signature Date

By signing this consent, I affirm that I am 18 years or older. If I am under the age of 18, my parent or legal guardian gives consent for transfer of records, in this case, this person attests they are, in fact, the legal representative of the minor.

_____ _____ _____
Parent/Guardian Date Date Received by Medical Records

_____ _____
Date Records Sent By