Vipool K. "Vic" Goradia, MD
Board Certified Orthopedic Surgeon
Sports Medicine & Arthroscopy

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize G2 Orthopedics and Sports Medicine to disclose or obtain the following information from the medical records of:

Name of Patient _____ Date of Birth _____

Chart Number _____ Telephone Number _____

Address_____

INFORMATION TO BE RELEASED: Please check the items applicable for information to be disclosed below:
Covering the period(s) of health care from _____ to _____
Date Date

☐Complete Health Records ☐History and Physical Exam ☐Progress Notes
☐X-Ray Reports ☐Photographs, Digital or other images ☐Lab Tests
☐Discharge Summary ☐Other (Please Specify) _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

**TO:** _____ _____
(Doctor, Attorney, Insurance Company, Self, etc.) Phone Number

_____ _____
Address (Street, City, State, and Zip) Fax Number

**FROM:** _____ _____
(Doctor, Attorney, Insurance Company, Self, etc.) Phone Number

_____ _____
Address (Street, City, State, and Zip) Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. Unless this authorization has been revoked in writing or a date/event/condition is listed here, this authorization will expire two years from date of signature.

Signature _____ Date_____
Patient or Legally Authorized Representative

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient

_____ _____
Signature of Witness Date