

MEDICAL RECORDS RELEASE REQUEST

Name of Facility and/or Physician: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: () _____

I, _____
(Please Print)

hereby give authorization to release confidential information regarding my medical status including the following information:

- 1.) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, or human immunodeficiency virus (HIV) infection, including, acquired immunodeficiency syndrome (AIDS), or tests for HIV;
- 2.) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living or my ability to work.

Please Mail and/or Fax Records to: **Orthopaedic & Sports Medicine at Cypress, LLC**
9300 E. 29th St. N.
Suite 205
Wichita, KS 67226
316-219-5899

For the purpose of:

- Continuing Medical Care Personal Use Information for Insurance Company
 Other (Please Specify) Information for Attorney

The following types of information are specifically authorized for release:

- Initial Evaluation Operative Reports Work Status
 Progress/Office Notes Discharge Summary Test Results
 X-ray only X-ray Report Medication listing

This authorization will expire on _____ or upon the occurrence of _____.

In signing this authorization, I understand and acknowledge the following (initial in the space provided):

- _____ I understand that this authorization is voluntary and that I may refuse to sign it.
 _____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.
 _____ I understand that I may revoke this authorization at any time by notifying the Practice in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to the Privacy Official, _____
 _____ I understand that, unless otherwise revoked, this authorization will expire upon the date or event set forth above.
 _____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

I, the undersigned, do hereby swear that I am the above-mentioned patient or a legal representative of the above-mentioned patient. I have read and understand the above information.

Date

Signature of Patient/Legal Representative

Printed Name of Legal Representative

Description of Legal Representative's Relationship to Patient



**Orthopaedic
Sports Medicine**
at Cypress

Bradley W. Bruner, M.D.
*Arthroscopic Knee Surgery
and Sports Medicine*

Phillip F. Hagan, M.D.
*Arthroscopic Knee Surgery,
Shoulder Surgery,
and Sports Medicine*

James Joseph Jr., M.D.
*Total Joint Reconstruction
of Knees and Hips*

Duane A. Murphy, M.D.
General Orthopaedics

Michael Easter, PA-C

Greg Knoblauch, PA-C

Tim Weide, PA-C

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