
# Medical Records Release Request

***Note: This form is used for when Newport Orthopedic is requesting patient medical records from other healthcare providers.***

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize and request the following provider indicated below to release any information, including the diagnosis, records of treatment, Imaging and/or examination records rendered to me for the period:

Start Date: _____ End Date: _____

Provider to Disclose PHI to Newport Orthopedic Institute:

To: _____

Street Address:_____

City, State, ZIP:_____

Phone: _____

Fax: _____

Please forward these records to:

**Newport Orthopedic Institute**
**22 Corporate Plaza Drive**
**Newport Beach, CA 92660**
**Fax (949) 630-4924**

This authorization shall be in effect until _____ (date)

Patient Name: _____

DOB: _____

Patient Address:_____

Patient Signature: _____ Date: _____

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