

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 A	Accountability Act (HIPAA), I hereby authorize
and request the following provider indicated belo	w to release any information, including the
diagnosis, records of treatment, Imaging and/or e	examination records rendered to me for the
period:	
•	::
Provider to Disclose PHI to Newport Orthopedic I	nstitute:
To:	
Street Address:	
City, State, ZIP:	
Dhonor	
Fa	
Please forward these records to:	
Newport Orthop	edic Institute
22 Corporate	Plaza Drive
Newport Beach	h, CA 92660
Fax (949) 6	30-4924
This authorization shall be in effect until	(date)
Patient Name:	
DOD:	
Patient Address:	
Patient Signature:	Date:

Version Date: 6/2016