Medical Record Request

Patient Information

Patient Name	Date of Birth	Date of Evaluation

Name of Employer	Date of Reported Work Injury

XstremeMD is the medical provider for the above-mentioned patient's employer. We are requesting the following records on this patient. Please see the attached Authorization to Release signed by the patient.

Please provide the following information:

- ☐ Complete medical record from authorized date of evaluation
- ☐ Radiology Report
- ☐ Other _____

Please send these records via email to _____ or fax at _____.

If you have any questions, please call XstremeMD at _____.

Request For and Authorization To Release Medical Records or Health Information

Privacy Act

This form authorizes release of information requested in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 in addition to those routine uses disclosures of the information authorized by HIPAA and in accordance with the Notice of Privacy Practice.

Patient Name:			
Date of Birth:		Telephone Number:	
Information may be released to: Purpose for Release of Information:	To: XstremeMD 1028 Forum Drive Broussard, LA 70518 Fax: 337-704-0897	For: At request of individual ☐ Case Management ☐ Other:	
Name of health care provider or entity to release this information:			
Address of above entity:			

Information to be released:

Expiration Date: This Authorization expires 2 years from date of signature below, unless otherwise revoked in writing.

_____ I hereby authorize the release of All MEDICAL RECORDS AND INFORMATION pertaining to my care and treatment for my Injury or Illness on the visit of _____ (DATE), and any subsequent visits or other encounters for such Injury or Illness, including but not limited to visit notes (history, physical examination and assessment), test results of any kind, radiology reports, referrals, consultant notes, billing records, insurance records, and ALL records created or received by XstremeMD for the care and treatment provided on all dates relative to my Injury or Illness.

_____ Limitation on release of information:

Acknowledgement

I request that health information regarding my care and treatment be released as set forth on this form and understand: 1) This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV related information only if I sign my name on the line below. 2) I have the right to revoke this authorization at any time by writing to XstremeMD at: 1028 Forum Drive Broussard, LA 70518. 3) I understand that signing this authorization is voluntary. I understand that information released pursuant to this authorization maybe subject to re-disclosure by the recipient and may no longer be protected by HIPAA. 4). My treatment will not be conditioned upon my authorization of this disclosure except as allowed by HIPAA for health care services that are solely for the purpose of creating protected health information for disclosure to a third party, like my Employer for purposes such as pre-placement physicals, drug tests, and fitness-for-duty examinations, and failure to provide authorization may result in termination of the patient relationship.

Additional Authorization for release of information:

I understand that this information may be used to adjust, describe, or report matters about my care and treatment to persons entitled to receive this information and I expressly authorize XstremeMD to engage in ORAL COMMUNICATIONS regarding my medical records and information as set forth above.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

_____ Patient Signature

_____ Date

_____ Witness Signature

_____ Date