



2861 NE Independence Ave, Suite 201
Lee's Summit, MO 64064

Office: 816-525-2840 | Fax: 816-525-2841

RELEASE OF INFORMATION

Last Name _____ First Name _____

Date of Birth: _____ SSN: _____

Address: _____ Phone: _____

Patient authorizes:

Facility: Advanced Orthopedics & Sports Medicine d/b/a Sano Orthopedics

Address: 2861 NE Independence Ave, suite 201, Lee's Summit, MO 64064

Phone: 816-525-2840 Fax: 816-525-2841 Attention: Medical Records

TO / FROM: Release Obtain Health Information

TO / FROM: Self Physician Facility Other _____

Name / Organization: _____ Attention: _____

Address: _____ City: _____ State _____ Zip: _____

Phone: _____ Fax: _____

- Complete Medical Records Operative Reports Medication Lists Hospital Reports
- Complete Billing Records Radiology Reports Work Status Notes Orders
- Progress Notes Radiology Images Lab Reports Other: _____

Dates Requested: Any dates before/after date of signature Or Date Range: _____

Purpose of Request: _____

Notes: _____

The information about you is protected under federal law and you have the right to revoke this authorization in writing. Please be advised that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. This authorization expires on the following date: _____ If left blank, I agree this authorization shall be valid for a period of twelve (12) months from today's date. All patients requesting medical records are required to show current identification for signature verification for the release of medical records.

Signatures

Patient Signature: _____ Date of Birth: _____

Printed Name: _____ Today's Date: _____