Medical Record Release of Information Authorization for Transfer from Reno Orthopedic Center to COR Spine and Pain Center

Patient Name: _____ Date of Birth: _____ Last 4 Digits of SSN: _____

Patient Address:_____ City: _____

State: _____ Zip Code: _____ Phone: (_____) _____-_____

I hereby authorize the release of my medical records,

From:

Reno Orthopedic Center

555 N Arlington Ave

Reno, NV 89503

Phone: 775-786-3040

Fax: 775-786-1358

To:

COR Pain and Spine

6255 Sharland's Avenue

Reno, NV 89523

Phone: 775-248-1267

Fax: 775-786-1358

I authorize this transfer to be made by email, fax and/or paper record transfer for the purpose of transfer of care. I authorize the transfer of all medical records pertaining to my care with Dr. Witmer at Reno Orthopedic Center from the first date of service to the current date.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will no apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

*This release expires one year from date signed, unless I specify an expiration date: _____

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature: _____ Print Name: _____ Date : _____

If signed by Representative, List Relationship to the Patient: _____