excel orthopedics

authorization to obtain medical records

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patient name | date of birth

address | social security number

I request and authorize **EXCEL ORTHOPEDICS** to obtain the healthcare info as stated below from:

name | phone number

address | fax number

city | state | zip code

This request and authorization applies to

healthcare information relating to the following treatment, condition, or dates

all healthcare information / other

I permit the release of all information indicated above including, if any, information concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV or other communicable diseases test results, and/or diagnosis and treatment.

I understand that this authorization will expire one (1) year from the date listed below.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, except to the extent the organization has taken action in reliance on the consent.

I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

relationship of representative to patient | date

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consent to obtain medication history

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, ad the drug history from your health plan might not include drugs that you purchased without your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

Additionally, please list your preferred pharmacy in the lines listed below

pharmacy

street address | street address line 2

city | state | zip code

phone number | fax number

I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

print patient name

signature of patient, parent or guardian | date