

**METROCREST ORTHOPAEDICS AND SPORTS MEDICINE**  
**RELEASE OF INFORMATION**

**Please allow up to 72 hours to receive your records and/or films. Records and/or Films at our offsite archive location may take up to 2 weeks before they are available.**

Today's Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Home Address (Street): \_\_\_\_\_  
(City): \_\_\_\_\_  
(Zip Code): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dates of treatment: \_\_\_\_\_ Relationship of requestor to patient: \_\_\_\_\_

Person or entity to whom records should be released: \_\_\_\_\_

Their address: (Street): \_\_\_\_\_  
(City): \_\_\_\_\_  
(Zip Code): \_\_\_\_\_

Reason for request of medical records: \_\_\_\_\_

Information to be released:

X-ray films or MRI Films  X-ray or MRI Reports  Other: \_\_\_\_\_

Metrocrest Orthopaedics and Sports Medicine will provide copies of all your films at a fee established by the Texas State Board of Medical Examiners. Copies will be provided at a fee of \$8 per film. Many of our older films are kept at an offsite storage facility and a \$20 fee will be charged to access these records in addition to the \$8 fee for each film copied. The patient may request to take their films to a different facility at no fee but a release form must still be completed. If the films that are requested for a different facility are in the archived storage facility, a \$20 retrieval fee will be assessed.

By signing this document I authorize Metrocrest Orthopaedics and Sports Medicine to release copies of medical records regarding my treatment, hospitalization, and/or outpatient care for my conditions. I understand that these records include, but are not limited to, psychological or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, AIDS (acquired immunodeficiency syndrome), AIDS Related Complex (ARC) and HIV antibodies testing, and I agree to its release.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information and Accountability Act of 1996. The facility, its employees, officers and Physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This document releases Metrocrest Orthopaedics and Sports Medicine from all legal liability that may arise as a result of the release of information requested.

I understand that my treatment cannot be conditioned on whether I sign this authorization form. I authorize to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for the records and films.

\_\_\_\_\_  
Signature of Patient or Legal Guardian Date

\*\*\*\*\*OFFICE USE ONLY\*\*\*\*\*

**Records Request completed By: \_\_\_\_\_ Date: \_\_\_\_\_**

**Films Request Completed By: \_\_\_\_\_ Date: \_\_\_\_\_**