



**PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I, \_\_\_\_\_, request that Tristate Orthopaedic Treatment Center release my protected health information to the entity below.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

The information I am requesting be sent includes (please check item desired):

- \_\_\_\_\_ Entire medical record
- \_\_\_\_\_ Medical Record during the period from \_\_\_\_\_ to \_\_\_\_\_  
Date Date
- \_\_\_\_\_ X-rays

I understand that Tristate Orthopaedic Treatment Center has up to 30 days to process my request if my information is maintained on site, up to 60 days if the information is maintained off site. A fee may be involved to duplicate the records/x-rays you are requesting. Please contact our Medical Records staff at 513-791-6611.

This authorization shall expire one (1) year from the date signed.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient or Authorized Representative Signature

\_\_\_\_\_  
Date