Northview Orthopaedic Associates

Orthopaedic Surgery | Open MRI | Ambulatory Surgery Center

Return completed form and email to:
medicalrecords@northviewortho.com

RECORDS REQUEST

Patient Information **MRN # _____**

PATIENT NAME		DATE OF BIRTH	LAST 4 OF SS#
ADDRESS	CITY	STATE	ZIP

Check here to send records to you at the above address ☐ OR complete below in full to send records to another physician.

OFFICE NAME	CONTACT NAME	TREATING DOCTORS NAME	
ADDRESS	CITY	STATE	ZIP
PHONE	FAX		

What Records Should be Released? DATE(S) OF SERVICE _____

____ All Records ____ X-Ray / MRI Report ____ X-Ray / MRI Discs
____ History & Physical ____ Consultation (s) ____ Operative Report
____ Other

What Format and Delivery Method Would You Prefer?

Format: ____ Paper ____ CD ____ PDF

Delivery Method: ____ Mail ____ Email

_____

- I hereby authorize Northview Orthopaedic Associates to disclose/release medical records and/or other information obtained during my diagnosis and/or treatment.
- I hereby release Northview Orthopaedic Associates from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

IF SIGNED BY LEGAL REPRESENTATIVE, **RELATIONSHIP** TO PATIENT:

IN OFFICE USE: DATE REQUEST RECEIVED: DATE PROCESSED:

Please allow 3-4 weeks to receive non-urgent records.