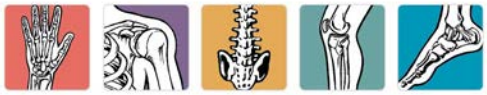

COLUMBIA ORTHOPAEDIC GROUP

1 South Keene Street · Columbia, Missouri 65201 · 573-443-2402

CONSENT AND REQUEST FOR RELEASE OF MEDICAL RECORDS

Please allow 5-7 business days for processing

Acct # (if known) _____ Name _____ Date of Birth _____

Disclosure of protected health information is made at the request for:

□ Insurance □ Referral □ Personal □ Physician

Records to be disclosed:

□ Clinic Notes □ Discharge Summary □ Operative Reports □ Radiology Films ($10 fee)

□ Diagnostic/lab Reports □ History & Physical □ Radiology Reports □ Surgical Pathology

□ Other specifics: _____

Records from (date) _____ to _____

Persons or facility who are authorized to receive records/information:

Name/Facility: _____ Phone: _____

Please complete more than one form if multiple providers are requested

Delivery method:

□ Pick up Desired date: _____/_____/_____

□ Mail Address: _____

City, State, Zip: _____

□ Fax _____

I hereby generally release and hold harmless the Columbia Orthopaedic Group (and all affiliated physicians) from all claims for damages or injury directly or indirectly caused as a result of disclosing said medical information or records to the above named authorized recipient(s). Revocation of this release must be in writing and may not be applied to retroactively.

_____ _____

Signature of patient (**if minor see below**) Date

Authorization for Minor or Incapacitated Patient

This portion of this form must be completed by someone who is acting on behalf of the patient in completing this form and in granting the authority hereafter described. If you are signing this form for someone else who has been treated by the Columbia Orthopaedic Group, you must have the authority to act on their behalf. By signing this portion of the form, you are representing and warranting to the Columbia Orthopaedic Group that you are authorized to act for the patient as that patient's parent or lawful guardian (if the patient is a minor) or as the guardian of the patient (if the patient is incapacitated).

I certify that I have the authority to execute this form on behalf of the person mentioned above:

_____ _____

Signature of guardian Date