



Kruger Orthopaedics, PLLC

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Note: A clerical fee for searching & handling may apply.

RECORDS RELEASE AUTHORIZATION

Patient Name: _____

Date of Birth: _____ Phone: _____

Release To: _____
Patient, Physician, Facility, or Relative

Address: _____

Phone: _____ Fax: _____

Please provide any and all pertinent medical information available concerning my:

- Records Only Operative Notes X-Ray Report X-Ray Disc
- MRI Report MRI Disc All

Specific Dates _____ Appt. Date: _____

Date Requested: _____ Initial: _____

Regarding Records Release:

When you authorize your records to be released, it is with the understanding that your records may contain information regarding the diagnosis or treatment of HIV, other sexually transmitted diseases, drug or alcohol use/abuse, mental illness, or psychiatric treatment.

Regarding X-ray Release:

We are pleased to provide you with these x-ray films and/or CD's with the understanding that they are a part of our permanent records. Images are the property of Kruger Orthopaedics, PLLC. Films should be returned within 30 days. Images are provided for clinical consultation facilitating the patient's diagnosis and treatment only.

We must have the patient's or guardian's signature in order to comply with the Uniform Health Care Information Act of 1991 in releasing medical records.

Patient Signature: _____ **Date:** _____

Print Name: _____ Patient Legal Guardian

OFFICE USE ONLY
Physician approval to distribute:
<input type="checkbox"/> YES <input type="checkbox"/> NO
SIGN _____