Heekin Clinic
ORTHOPEDIC EXCELLENCE

R. David Heekin, MD
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AUTHORIZATION REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

(Outside Medical Records Request Form)

I hereby authorize use or disclosure of health information as described below for continued healthcare to:

Requesting Physician: R. David Heekin, MD
Patient Name: _____
Date of Birth: _____
Phone Number: _____

Attention: _____
Social Security Number: _____
Alternate Number: _____

PLEASE INCLUDE:

Medical Records:

- ☐ Initial Patient Paperwork / Questionnaires
- ☐ Office Notes (Dates: _____)
- ☐ Itemized Billing (Dates: _____)
- ☐ Physical Therapy Notes

Hospital Records:

- ☐ Consult
- ☐ History & Physical
- ☐ Operative Report
- ☐ Discharge Summary

Diagnostic Imaging:

Body part of concern: _____

- ☐ X-ray Films / Disc
- ☐ Laboratory Tests
- ☐ Diagnostic Reports (Type: _____)

Other: _____

I acknowledge that I have read this authorization and fully understand its contents.

Patient Name: _____ Date: _____

Patient/Parent/Guardian Signature: _____ Date: _____