PLEASE INDICATE PHYSICIAN

☐ Dr. Kapp
☐ Dr. Dounchis

NCH Physicians Group
Department of Orthopedic Surgery
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Phone: 239-434-5700 Fax: 239-434-8605

OFFICE USE ONLY:

Initials: _____

Date: _____

RECORD RELEASE REQUISITION
RELEASE FROM ORTHO

By signing this request, I authorize **Howard J. Kapp, MD** and/or **Jon S. Dounchis, MD** to share my medical records and/or x-ray films (or those of my minor child(ren)) with myself or the provider or facility listed below.

NAME OF PATIENT: _____ PHONE NO. _____

DOB: _____ ACCOUNT NO. _____

[ ] X-RAY FILMS [ ] X-RAY CD [ ] X-RAY REPORT [ ] MRI REPORTS
[ ] OFFICE NOTES [ ] OP REPORT [ ] LABS

_____
Dates of records requested / Procedure performed / Outside imaging performed

[ ] I would like to pick up my records/x-rays.
[ ] Downtown [ ] Creekside

Pickup date: _____

[ ] I would like my records mailed to me at:

_____ Recipient

_____ Address

_____ City/State/Zip

[ ] I would like my records fax to me at:

_____ Fax Number

[ ] I would like my records mailed to the provider or facility at:

_____ Provider

_____ Address

_____ City/State/Zip

[ ] I would like my records faxed to the provider or facility at:

_____ Provider

_____ Fax Number

_____ Phone Number

This request allows **Howard J. Kapp, MD** and/or **Jon S. Dounchis, MD** to share information for the purpose of my treatment and continuity of health care.

_____ _____
Signature of Patient or Legal Guardian/DOB Today's Date

_____ _____
Signature of Staff Rep. Completing Request Date Processed