HealthPort HealthPort Technologies, LLC, contracts with

Danville Orthopaedics & Sports Medicine
333 S. Third Street Suite B
Danville, KY 40422

to process copies of health records.

****PLEASE FILL IN ALL BLANKS****

YOUR (PATIENT) NAME:_____MRN#_____

DATE OF BIRTH:___/___/_____SOCIAL SECURITY #:_____-_____-_____

MAILING ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE:_____CELL:_____

EMAIL ADDRESS:_____@_____
(optional but required for electronic delivery of your record)

I, (name listed above), do hereby authorize HealthPort to copy medical records on behalf of Danville Orthopaedics and Sports Medicine and send them to me or my designee.

Fees: I understand the first copy of my record is free. Copies of other facilities' records and second request copies will be billed at the rate allowed by the Commonwealth of Kentucky at **$1.00** per page. Upon receipt of an invoice from HealthPort, I agree to pay any charges for records copied within 30 days of receipt.

I request copies of the following: (Please allow 30 days from the time this request is received at the address listed above for processing the records.)

_____ COMPLETE MEDICAL RECORDS FROM **DOSM**

_____SPECIFIC DATES OF SERVICE:_____
(PLEASE GIVE MONTH, DAY, AND YEAR)

_____OTHER (Specify what is needed and date:)_____
(PLEASE GIVE MONTH, DAY, AND YEAR)

PLEASE SEND THE RECORDS TO (If other than patient listed above):

NAME:_____

MAILING ADDRESS:_____

CITY:_____ST:_____ZIP:_____

PATIENT SIGNATURE:_____DATE:_____