RICHARD D. JELSMA, MP
Board Certified Orthopedic Surgeon
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Consent for the Release of Medical Records

I hereby authorize Dr. Richard Jelsma to release the following information from the medical records of:

Patient Name: _____

DOB: _____ Account #: _____

Information to be released:

_____ Copy of complete medical record(s), including, if any, information about drug or alcohol abuse or treatment, infections or contagious disease information including HIV confidential information, and/or psychiatric or psychological information.

_____ X-rays and/or x-ray results

_____ Billing information only

Information released to: _____

Address: _____

Purpose of release: _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Unless otherwise stated below, this consent shall automatically expire ninety (90) days from the date set forth below, or upon the following date, event, or condition.

The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

I have read and understand the consent for release of medical information, and have voluntarily and knowingly signed this consent

Patient or Guardian Signature, if patient is a minor: _____

Patient Name: _____

Date: _____