

# Seaview Records Service

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Email: [myrecords@seaviewortho.com](mailto:myrecords@seaviewortho.com) Website: Seaviewortho.com

## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ Seaview Orthopaedics & Medical Associates \_\_\_\_\_ to release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

Physical Therapy Treatments

Other: \_\_\_\_\_

**Fees For Copies:** Federal and State law permit a fee to be charged for the copying of records. Your copies will be available and released within 3 to 5 business days once payment is received. The fee for records is \$1.00 per page. Maximum is \$100.00. Postage is not included.

Payment can be made by credit/Debit Card, Cash or Checks.  
Make Checks Payable to: **Seaview Records Service**

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. **If you do not make a selection, these records will be released as a part of your records.**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.