MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____ **Phone Number:** _____

I hereby request that a copy or summary of my records, including laboratory or x-ray reports that you may have which contain information relevant to my present and future diagnosis and/or treatment to be released from/to Allied Orthopaedics and/or Direct Orthopedic Care from/to the following Medical Office, Health Care Provider, or Person(s):

Name of Medical Office, Health Care Provider, or Person(s):

_____

Address: _____

Phone Number: _____ **Fax Number:** _____

SPECIFIC AUTHORIZATION

Treatment Authorizations **Test Results** **HIV (AIDS)** **Substance Abuse** **Mental Health**

I acknowledge that data to be released may include material that is protected by Federal Law and that is applicable to ANY of the above. My signature below authorizes release of all such information except as otherwise specified (to exclude specific information, please cross out and initial the items not to be released in the list above titled "SPECIFIC AUTHORIZATION").

Patient/Legal Guardian Signature: _____ **Date:** _____