

ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

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MEDICAL RECORDS RELEASE

Date:

Patient Name:

Date of Birth:

I hereby authorize you to release medical records to patient or Doctor.

Name:

Address:

Address:

Telephone:

Any information including the diagnosis and records of any treatment or examination rendered to me by Advanced Orthopaedics and Sports Medicine.

Patient/Guardian Name (Printed)

Patient/Guardian Signature

Date