



Sports Medicine • Joint Reconstruction • Hand Surgery • Spine Surgery

Authorization for Release of Patient Records

Name of Patient _____

Date of Birth _____

Send Records to: _____

I authorize release of medical records including reports involving
(PLEASE CHECK ALL THAT APPLY):

- Alcohol / drug abuse
- Mental illness / psychiatric treatment
- AIDS-related information, diagnosis, test results

Use the check list below to specify category(s) necessary for copying:

- Clinic / Progress notes
- Operative reports
- Laboratory reports
- Pathology reports
- Consultation reports
- X-ray reports
- Other -- Please specify _____

Release records from: _____

This authorization will remain in effect for a maximum of one year from the date of signature and may be cancelled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

Date: _____

Signature: _____

Address: _____

Phone: _____

J. William Follows, MD Rick D. Wilkerson, DO Philip A. Deffer, Jr., MD Stephen J. Frushour, MD Jason C. Hough, DO

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