RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____ DATE: _____

I HEREBY AUTHORIZE YOU TO RELEASE ALL OF MY MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATEMENT DURING THE TIME I AM/WAS UNDER YOUR CARE TO:

_____

_____

_____

PHONE: _____ FAX: _____

SIGNATURE:

_____

PRINT NAME:

_____

Relationship if other than patient: _____

Records to be release by:

Orthopaedic Associates of Miami Lakes
15600 NW 67th Ave
Ste 306
Miami Lakes, FL 33014