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Authorization for Release of Medical Information

I, ______________________________ give Orthopaedic Institute of Northwest Florida permission to release and/or discuss my medical records or conditions with the following individual(s):

Name:	Phone Number:	Relationship to the patient:
______________________	______________________	________________________
______________________	______________________	________________________
______________________	______________________	________________________
______________________	______________________	________________________

Patient, Parent, or Legal Guardian: ________________________________

Signature: ____

Date: ____

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CHILDREN'S ORTHOPAEDIC INSTITUTE OF NORTHWEST FLORIDA
Specializing in Pediatric Orthopaedics and Scoliosis Surgery