PERSONS
ORTHOPAEDIC SPORTS MEDICINE
& JOINT REPLACEMENT CENTER

RELEASE OF MEDICAL INFORMATION

____Entire Record _____Verbal Information To: _____

____Partial Record to include: Office notes ___ OP notes ___ XRAYS___ Operation Images___

Patient's Name _____ DOB _____

Social Security Number _____

Address _____

City/State and Zip _____

PLEASE RELEASE MY MEDICAL RECORDS

TO DR. _____

LOCATION _____

FAX: _____

Patient Signature: _____

Date: _____Date Sent: _____

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