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MEDICAL INFORMATION RELEASE

I, ________________________________, hereby give authorization for release of my medical records to:

Name of facility/Doctor ____________________ Phone# ____________________

Address ____________________ Fax# ____________________

CHECK EACH LINE THAT APPLIES TO INFORMATION NEEDING TO BE RELEASED:

____ Any information acquired in the course of my examination and/or treatment contained in my chart at Florida Center for Orthopaedics.

____ Treatment and diagnosis concerning mental health/rehabilitation may be released to the recipient noted above.

____ X-Rays/MRI's, Diagnostic testing, and Doctor's notes.

I UNDERSTAND THAT THIS CONSENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Signed: ______________________________ Date: ______________________
(If under 18 years of age, parent or guardian)

Patient's name as it appears on record ____________________ Date of Birth ____________ Chart# ____________

Treating Doctor ____________________ Patient's Contact Phone# ____________________ Athena# ____________