FAMILY AND FRIENDS ORTHOPEDICS, PLLC

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Authorization to Release Medical Information

Patient Name:_____Date of Birth:_____

Address:_____City, State, Zip:_____

Release Medical Records to: _____

_____

_____

Phone #_____Fax #_____

Information to be released:___X___ Complete Medical Records:_____ Other:_____

Purpose for Disclosure – (Choose Reason)

_____ Personal Copy - $25 Charge

__X___ Further Medical Care – Sent Directly to Physician/Doctor

I agree that any information regarding drug and/or alcohol abuse, communicable disease(s), psychiatric, and/or HIV/Aids, genetic testing may be released.

_____Yes (Initials) _____No (Initials)

I agree that any medical billing record(s) containing information in reference to drug and/or alcohol abuse, communicable disease(s), psychiatric, and/or HIV/Aids, genetic testing may be released.

_____Yes (Initials) _____No (Initials)

I further authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to revoke this request. Additionally, I hold harmless Family and Friends Orthopedics, PLLC, its agents and employees from any recourse due to any loss, claims for injury or damage, costs, expenses, neglect, or injury or damage caused by any unintentional acts or omissions.

Signature of Patient:_____Date:_____

Authorized Signature:_____Relationship:_____Date:_____