pediatric
sports & spine associates

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient name: _____ **Date of Birth**: _____

I as the patient or legal representative of the patient, request that the following protected health information (medical records) be released for treatment purposes:

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Entire Record
☐ Operative Report
☐ Progress Notes
☐ Other: _____
☐ History and Physical
☐ Labs, X-rays, Pathology, MRI, CT scan
☐ Information relating to _____

_____ _____
Signature of Patient or legal Guardian Date

_____
Relationship

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED