# ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

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# MEDICAL RECORDS RELEASE

Date: ______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

I hereby authorize you to release medical records to patient or Doctor.

Name: ______________________________

Address: ______________________________

Address: ______________________________

Telephone: ______________________________

Any information including the diagnosis and records of any treatment or examination rendered to me by Advanced Orthopaedics and Sports Medicine.

______________________________
Patient/Guardian Name (Printed)

______________________________ ______________
Patient/Guardian Signature Date