Date: _____

Patient Name (please print): _____

Patient Date of Birth: _____ (MM/DD/YYYY)

Patient Social Security # _____ (xxx-xx-xxxx)

Patient's Phone #: (_____) _____

I authorize Non-Surgical Orthopaedics, PC to release my medical information to:

Name of Practice / Doctor / Person: _____

Address: _____

_____

Phone #: (_____) _____

Fax #: (_____) _____

What records would you like sent: (**choose one**)

☐ **Most Recent**
☐ **Entire**
☐ **Other / Specific:** _____

Please be aware that Non-Surgical Orthopaedics, PC requires a minimum of 72 hours to process records. With authorization, records may be faxed in emergency situations only.

Patient Signature: _____

I understand that by signing above, I authorize Non-Surgical Orthopaedics, PC and The Center for Spine Procedures, PC to release any medical or personal information requested including electronically prescirbed prescriptions, records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse. I have read the Practice Policy Book and will be bound by the provisions contained therein, including all rights under HIPAA.