

orthomemphis



ORTHOMEMPHIS

Patient Name: _____

DOB: _____

Age: _____

Gender: _____

Authorization to Release Records

Date: _____

Full Name of Patient _____

Date of Birth _____ Social Security # _____

I authorize and request **orthomemphis** to release my/patient's medical records to:

Name _____ Phone # _____

Fax # or Mailing Address _____

Covering treatment from _____ to _____

The purpose of this disclosure is: _____ Changing Physicians
_____ Litigation
_____ Insurance Claim
_____ Other (Specify) _____

I understand that my release shall not constitute a breach of my right to confidentiality.

This authorization expires on _____

Patient or Guardian's Signature _____

Relationship to Patient _____

Patient's Home Address _____

Home Phone# _____ Work Phone# _____

Payment Received on _____ for \$ _____ Cash or Check# _____

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