UBMD ORTHOPAEDICS & SPORTS MEDICINE

Release of Information

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Last Name: _____ First Name: _____

Previous Name: _____ Date of Birth: _____

☐ I authorize and request healthcare information for the abovementioned patient be released to UBMD Orthopaedics & Sports Medicine

☐ I authorize and request UBMD Orthopaedics & Sports Medicine to release healthcare information for the abovementioned patient to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Parent/Legal Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED