



**ORTHOPEDIC SURGEONS**

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**MEDICAL RECORDS RELEASE AUTHORIZATION**

PLEASE PRINT NAME CLEARLY \_\_\_\_\_

PHONE: (    ) \_\_\_\_\_ - \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

I HEARBY AUTHORIZE JOINT IMPLANT SURGEONS OF FLORIDA TO RELEASE COPIES OF MY MEDICAL RECORDS (Reports only) TO THE FOLLOWING PROVIDER:

|                  |       |
|------------------|-------|
| DOCTOR'S NAME    | _____ |
| DOCTOR'S PHONE # | _____ |
| DOCTOR'S FAX #   | _____ |

PURPOSE OF RELEASE (CHECK ALL THAT APPLY)

\_\_\_\_\_ CONTINUING OF CARE

\_\_\_\_\_ PERSONAL

\_\_\_\_\_ INSURANCE

\_\_\_\_\_ LITIGATION

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

THIS AUTHORIZATION EXPIRES ON THE FOLOWING DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

(IF DATE OF EXPIRATION IS NOT SPECIFIED, THIS RELEASE EXPIRES ONE YEAR FROM TODAYS DATE)

**\*\*NOTE: MEDICAL RECORD REQUESTS TAKE (7) SEVEN TO (10) TEN BUSINESS DAYS TO PROCESS**