orthopaedicseast
& SPORTS MEDICINE CENTER

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RELEASE OF INFORMATION TO ORTHOPAEDICS EAST & SPORTS MEDICINE CENTER

Patient Name: _____

Patient Date of Birth: _____

Please release my records from:

_____

_____

_____

_____

to Orthopaedics East & Sports Medicine Center

Patient/Authorized Signature: _____ **Date:** _____

Relationship to Patient: _____

Witness Signature: _____ **Date:** _____

I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken upon this authorization. Unless revoked earlier, this authorization to use or disclose your health information will expire one year from the date of this authorization.