PRESTIGE ORTHOPAEDICS
& SPORTS MEDICINE

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Please note that there is a $25 fee for release of medical information.

Request of Medical Information

1. **Authorization:** I authorize disclosure of medical information and health records as described below:
   Name of Patient:___________________________Date of Birth:_________________

2. **Record Holder:** ____

   ____
   Street Address City State Zip

3. **Records May Be Released To**: ____

   ____
   Street Address City State Zip
   FAX: ______________________________________

4. **Type of Information:** This authorization is limited to the following type(s) of information unless my initials appear beside each applicable category.
   ( )Records Only ( )Labs ( ) X-Rays ( ) PT ( ) Billing ( ) MRI
   ________Other (Please Specify) ____
   Protected Information: Please check and initial below information to be released
   ( ) Mental Health ( ) Alcohol/Drug ( ) HIV Results

5. **Date of Service:** From _______/______/_________ To_______/______/_________

6. **Duration:** This Authorization is valid for one year from the date next to my signature, unless otherwise noted here: ____

7. **Signature:**
   Printed Name: ____

   Signature: ____Date/Time: _______________

   If signed by other than patient, indicate relationship to patient: ____________________

   Witness Signature: ____Date/Time: ________