AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION AND RECORDS

From the Records Compiled on:

______________________________ ____________________ ____________
Patient Name SSN DOB

____ do hereby authorize:
Parent or Legal Guardian

1. ____ ______________________
   Complete Name, Address of Person/Agency with Possession of Records — Date of Treatment of Problem Treated

2. ____ ______________________
   Complete Name, Address of Person/Agency with Possession of Records — Date of Treatment of Problem Treated

3. ____ ______________________
   Complete Name, Address of Person/Agency with Possession of Records — Date of Treatment of Problem Treated

4. ____ ______________________
   Complete Name, Address of Person/Agency with Possession of Records — Date of Treatment of Problem Treated

To release any and all medical records and information concerning me to:

The Orthopaedic Center
927 Franklin Street
Huntsville, AL 35801
Phone: (256) 539-2728
Secure Fax: (256) 539-2666
www.visitTOC.com

____ ______________________
Patient Signature Date

____ ______________________
Witness Signature Date