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