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Authorization To Release Patient Information

I hereby consent to the disclosure of the specific information listed below, as it concerns:

Patient: _____ **DOB:** _____

Person Requesting Records : _____

Send Records To: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Fax #:** _____

For the release of:

Office Notes **X-Rays** **Operative Reports**

Date of Appointment with Other Physician: _____

Reason for Records:

Second Opinion **Bracing** **Legal File** **Insurance**
Personal **Other**

Please Specify: _____

Dr. Love, M.D. **Dr. Neustadt, M.D.** **Dr. Beck, M.D.** **Dr. Hahn**
Dr. Novick, MD **Dr. Roberts, M.D.** **Dr. Warnick** **Dr. Benfanti**

Dr. Signature _____ **Date:** _____

Date Copy of C.O.S.S.A. records are needed: _____

Note: This consent is subject to revocation at any time, in writing, but may not be revoked to include the release allowed by this document. Unless otherwise specified, this authorization will be valid for a period of six (6) months following the date of signature.

Parent/Guardian Signature _____ **Date** _____

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