JOINT Replacement Institute

TO OBTAIN MEDICAL RECORDS FROM ANOTHER DR AUTHORIZATION

Date: _____

Patient Name: _____ DOB: _____ SS#: _____

I Hereby Authorize: _____

_____

_____

To release copies of the following:

_____Medical Records _____Medical Records & X-Rays _____X-Rays _____Psych Eval

_____HIV/AIDS Treatment _____Hepatitis C Testing _____Alcohol/Drug Abuse Eval

To: JOINT REPLACEMENT INSTITUTE

Purpose of Release: _____Continuing Care _____Insurance _____Litigation _____Personal

This Authorization expires on the following date: _____(If no date is specified, this release expires one (1) year from today's date.)

I understand there will be a $10.00 charge for x-rays and agree to pay for the copies at the time of pick-up.

_____

Patient Signature

3466 Pine Ridge Road, Suite #A, Naples, FL 34109 · Phone: (239)261.2663 (BONE) · Fax:(239)262.5633 (KNEE)