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## **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name:	D.O.B:
Address:	Phone No:
I,	, authorize to release healthcare
information to:	
Southland Orthopaedics	
Dr. Ram Aribindi, M.D, FRCSC	
☐ Dr. Adam Kahn, M.D	
with the Most Recent:	
☐ Office/Progress Note ☐ Imaging (MRI, CT, X-Rays, Ultrasound) ☐ Laboratory Results ☐ Other	
Note: * Please Fax: 1-708-283-1250 If there are any questions or clarifications, please co	
Printed Name of Patient/	Signature of the Patient/
Personal Representative	Personal Representative
Doto	