TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE

MEDICAL RELEASE FORM

Patient Name: _____ DOB: _____ / _____ / _____

SSN #: _____-_____-_____ Phone: (_____) _____-_____ Email: _____

Address: _____ City: _____ State: _____

Zip Code: _____

INFORMATION REQUESTED FROM:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____-_____

Fax: (_____) _____-_____ Email: _____

SEND INFORMATION TO:

Send by: ☐ Mail ☐ Fax ☐ Secure email ☐ Pick up

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____-_____

Fax: (_____) _____-_____ Email: _____

TYPE OF RECORD REQUESTED: _____

I, _____ (Name), hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed above.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____