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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

By signing this form, I authorize 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 Relevé Sports Medicine.

Office requesting records from: _____

Physician Name: _____

Office Number: _____

Fax Number: _____

Date of records needed: _____

The information you may release subject to this signed release form is as follows:

☐ Complete Records ☐ History & Physical ☐ Progress Notes

☐ Care Plan ☐ Lab Reports ☐ Radiology Reports & Images

☐ Pathology Reports ☐ Treatment Records ☐ Operative Reports

☐ Hospital Reports ☐ Medication Records ☐ Other (please specify below)

The purpose/reason for this release of information is:

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Legal Representative

OUR GOAL IS TO GET YOU TO YOUR HIGHEST POTENTIAL