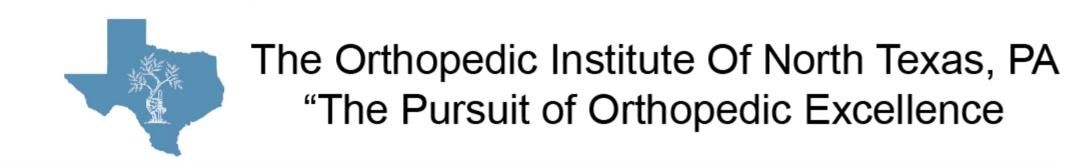
Authorization for Release of Information



I hereby authorize									
Entity or Person from whom records are requested					Address				
other such related understand that m	eases such as psychotherapy information. y health care a	entifiable he Human Immuy notes), cher I understand and the payme	nodeficiency Viru nical or alcohol d that this authoriza ent of my health c	as descres ("HIV") as ependency ation is vo	nd Acquired Immu I, laboratory test related luntary and I may t be affected if I do	ne Deficiency esults, medica refuse to sign not sign this fo	Syndrom l history, this authorm.	e ("AIDS"), mental treatment, or any	
care provider; the	•						•	ally of Holl-Health	
Patient Name (plea	ase print)				Date of Birth	Socia	al Security	/ Number	
Patient Address (City, State and Zip)						Phone Number			
Specific Date(s) of Service (if known)						All Dates of Service			
Information to be i	released: (Che	ck all that app	oly)						
Complete Med	lical Records	Radiology	Reports & Films	Regis	tration Records	☐ Billing R	Records		
☐ Visits & Encour	nters	Laborato	ry Reports	Cons	ultation Reports	Emerge	ncy Roon	า	
Laboratory Rep	orts	Operative	e Records	☐ Othe	r:				
Description of the	purpose of the	use and/or d	isclosure:						
The health informa	ation described	herein shall	be <u>released to</u> :						
Category: Hos	spital 🔳 Ph	ysician \Box	Insurance Compar	ny 🗌 A	ttorney 🗌 Patie	nt 🗌 Other			
The Orthopedic Institute of North Texas, PA						972-591-6468			
Name of Person or Entity (please print)						Phone Number			
5575 Warren Parkway, POB 1, Suite 115, Frisco TX 7503					34	972-	591-64	-69	
		Address (Cit	y, State, and Zip)				Fax Numb	per	
Delivery Method:	☐ Mailing	Address	Fax Pic	k-Up Reco	rds 🔲 Othe	er			
I understand that the this authorization to		•	•	from the piration dat		ization unless	l otherwi	se specify. I desire	
	must be signe	ed and dated v	with a date that is					nderstand that the tion will not affect	
Signature of Patient, Parent, or Legal Guardian					Date				
Printed Name o		rent, or Leg	al Guardian						
Relationship to	Patient			or	Legal Autho	Prity (Attach S	upporting	g Documentation)	

Version: 04/16/13 External Other