Freiberg Orthopaedics & Sports Medicine

Specializing in:
Arthroscopic Surgery
Back Disorders
Disc Surgery
Foot Surgery
Hand Surgery
Neck & Spine Surgery
Pain Management
Pediatric Orthopaedics
Reconstructive Surgery
Scoliosis
Sports Medicine
Total Joint Replacement
Trauma / Fractures

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FOUNDED IN 1890
Entering our third century of excellent Orthopaedic care.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize the Freiberg Orthopaedic Group to release a copy of my (or give relationship_____) medical records or other information regarding my treatment, hospitalization, and/or outpatient care, including psychiatric/psychological conditions, drug or alcohol abuse, drug-related conditions, alcoholism, HIV testing or treatment of AIDS and AIDS-related conditions.

I request that these records be forwarded to:

_____
Name

_____
Address

_____
City, State, Zip Phone #

The above information is requested to be released for the following purposes only:

REDISCLOSURE OF THE ABOVE INFORMATION REQUIRES SEPARATE WRITTEN AUTHORIZATION.

This statement must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire in sixty (60) days after the date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the above treatment records.

_____
Patient's Name (Please Print) Maiden Name (if applicable)

_____
Address

_____
Birthdate

_____ _____
Signature of Patient Date

_____ _____
Other person legally authorized to give consent Witness

_____
Relationship to patient and reason