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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

*FORM MUST BE FILLED OUT **COMPLETELY** OR RECORDS WILL NOT BE SENT ● PLEASE PRINT NEATLY*

I Authorize: OrthoBethesda
10215 Fernwood Rd
Suite 506
Bethesda, MD 20817

Treating Physician:_____

•To Release to:

_____ _____
Name of receiving person or organization Phone Number

_____ _____
Street Address Fax Number

_____
City, State, Zip Code

•Information to be Released: (check applicable)
____All progress notes ____Surgical reports ____Other(please specify)_____

•Records from Time Period: ___/___/___to___/___/___

•Medical Records pertaining to my Illness/Injury of:_____

•Purpose or Need for Disclosure: (check applicable purposes)
____2nd Opinion ___Personal ___Physical Therapy
____Pain Management ___Legal ___Worker's Compensation Claim
____Other (please specify)_____

$0.76 per page x _____ = _____

_____ _____
Patient's Name (at time of treatment) Patient's Social Security Number

_____ _____
Street Address Patient's Date of Birth

_____ _____
City, State, Zip Code Daytime Phone Number

_____ _____
Signature/Relationship to Patient Date

******(CANNOT SEND WITHOUT SIGNATURE) ******