

ORTHOPAEDIC SPECIALISTS OF TEXAS

1201 BROOKS ST., SUGAR LAND TEXAS 77478
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I hereby authorize Orthopaedic Specialists of Texas to release information from the medical record(s) of:

Patient Name: _____

Date of Birth: _____ SSN# _____

PURPOSE OF RELEASE: (Circle one)

Continuing Medical Care Insurance/Disability Review Legal/Attorney Review Personal Records

Other: _____

DATES OF CARE: _____ INFORMATION TO BE RELEASED: (Circle one)

All Records History Progress Notes Lab Reports X-Rays / MRI
Care Plan Physical Operative Notes EKG Report Therapy Reports

RELEASE INFORMATION TO: (Fill out completely)

Name: _____			
Address: _____	City: _____	State: _____	Zip: _____
Phone and/or fax #: _____			

AUTHORIZATION

Orthopaedic Specialists of Texas, its employees, officers, and physicians are released from legal responsibility and liability for the release of the above medical information including release of any psychiatric, communicable diseases (including HIV), alcohol or drug abuse information.

This signed authorization expires in 180 days.

A copy of this consent shall be considered as effective as the original.

Signed: _____ Date: _____
(Patient or legal representative)

(Relationship to patient) Phone: _____