RECORDS RELEASE

(PLEASE PRINT)

DATE:_____

PATIENT LEGAL NAME:_____

DATE OF BIRTH:_____ SS#:___***-**-_____

PURPOSE FOR MEDICAL RECORDS RELEASE:_____

_____

TO:_____

_____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE COPIES OF MY RECORDS, INCLUDING X-RAYS, TO:

KENNEDY-WHITE ORTHOPAEDIC CENTER

6050 Cattleridge Blvd, Suites 201 & 301, Sarasota, FL 34232

Phone (941) 365-0655 Fax (941) 366-8043

Please

- ❑ Fax
- ❑ Mail

_____ _____

Patient Signature Date

Approved by:_____

Kennedy-White Orthopaedic Center reserves the right to charge a fee for this service.
This authorization may be revoked at any time by written request to Kennedy-White Orthopaedic Center.
The undersigned acknowledges that a refusal to sign this form will not result in a denial of health care treatment.