

JEFFREY L. HALBRECHT, M.D., P.C.

Orthopedic Surgery & Sports Medicine

•

Arthroscopic Surgery

Surgery of the Knee and Shoulder

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT'S NAME: _____

DOB: _____

ADDRESS: _____

PHONE NUMBER: _____

I hereby authorize _____ to release healthcare information to _____

THIS REQUEST AND AUTHORIZATION PERTAINS TO:

_____ ALL HEALTHCARE INFORMATION

_____ ALL RADIOLOGICAL STUDIES (X-RAY, MRI, BONE SCAN ETC...)

_____ REPORTS

I HEREBY RELEASE THE ABOVE MENTIONED FACILITY AND IT'S STAFF FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THE ACT HEREBY AUTHORIZED.

I AGREE THAT ANY EXPENSE FOR THE ABOVE MENTIONED SERVICES SHALL BE MY RESPONSIBILITY.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE