



Records Release

Date _____

To **Orthopedic Center of Palm Beach County**

I hereby authorize and request you to release the complete medical records in your possession, concerning my illness and/or treatment during the period from _____ through _____ to the physician(s) named below. Incorporated in this release form is my authorization for you to include any and all information relating to HIV testing and other AIDS diagnostic techniques.

Physician's Name _____

Address _____

City _____ State _____ ZIP _____

SIGNED

(Patient or Authorized Person)

(Relationship if other than patient)

Print Patient's Name _____

Patient's Date Of Birth _____

Patient's Social Security # _____

Thank you for your prompt response to this request.