



Records Request

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 me at the address noted below:

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.