



ORTHOPEDIC CENTER  
OF PALM BEACH COUNTY

# Release Of Information

I \_\_\_\_\_  
(Print Name)

Hereby Authorize \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO RELEASE ALL INFORMATION CONTAINED IN MY RECORD REGARDING MY TREATMENT.

To: **Orthopedic Center**  
Fourth Floor - attention medical records \_\_\_\_\_  
4801 S. Congress Avenue (Doctor's Name)  
Lake Worth, FL 33461

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

\_\_\_\_\_  
(Signature) (Today's Date)

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————— All Offices: (561) 967-6500 —————  
LAKE WORTH OFFICE • 4801 South Congress Avenue, Lake Worth, FL 33461 • Fax (561) 433-4175  
WELLINGTON/PALMS WEST OFFICE • 12983 Southern Blvd., Suite 101, Loxahatchee, FL 33470 • Fax (561) 790-4055  
BOYNTON BEACH OFFICE • 6056 Boynton Beach Blvd., Suite 215, Boynton Beach, FL 33437 • Fax (561) 967-6500