Orthopaedic Surgery

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RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Louisville Bone & Joint Specialists, PSC is hereby authorized to release my medical records and information pertaining to my medical care and treatment to:

Facility _____

Address _____

_____

Phone _____

If only specific records are being requested please complete:

**Please send only records pertaining to my _____(body part/injury). This injury occurred on or about _____(date of injury).

Signed: _____
(Parent or legal guardian if patient is a minor) Date
Printed Name: _____

LBJS use only:
Date Sent: _____ By: _____

Please check one: □ Mail □ Fax □ Hand Delivery