LEDERMAN KWARTOWITZ
Center for Orthopedics & Sports Medicine

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:

Date of Birth: **Social Security #:**

I hereby authorize _ to release the following information for evaluation and treatment:

Diagnostic Testing: _____

Office Notes: _____

Physical Therapy Notes: _____

Surgical Reports: _____

X---Ray Films: _____

Other (Describe): _____

Release to:

Name: _

Address: _

Phone: **Fax:** _

I hereby authorize the release of information contained in my patient records, including alcohol and drug abuse records protected under the regulations in code 42 of Federal Regulations, Part 2, if any; Psychological Services Records, if any; and Social Services Records, if any; including communications made by me to a Social Worker or Psychologist. According to regulations protected under PA 488, this authorization shall include disclosure of information pertaining to communicable diseases or infections which includes, but is not limited to the following: HIV, Acquired Immunodeficiency Syndrome Related Complex VD, Tuberculosis, Meningitis, and Hepatitis A & B.
I permit a copy of this authorization to be used in place of the original.

Please initial the appropriate choice:

☐ This authorization will remain in effect until such time as Ronald S. Lederman, M.D. is given written notice revoking it.

☐ This authorization expires upon initial compliance with request.

X_

Patient/Guardian Signature **Date**

Last Update 4/6/15 mkb

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