KATZ ORTHOPAEDIC INSTITUTE
RICHARD J. KATZ, MD, FAOS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Physician / Practice / Hospital Name: ______________________________ Date of Request: __________

Address: ____

City: ______________________________________ State: ______ Zip code: ______________

Phone #: ____________________________ Fax #: ________________________

The following has asked that medical records be released and forwarded to our office as soon as possible.

Patient Name(s): ________________________________ Date of Birth: ________________

Patient Phone # ________________________________

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our requests for copies of all relevant records in your file. Please be sure to include radiology reports, lab results, consultation reports, emergency room reports and any hospitalizations from the time they have been a patient in your practice or at your hospital. Thank you for expediting this request.

Please send the records to our office:

Katz Orthopaedic Institute
14153 Yosemite Drive
Suite 103
Hudson, FL 34667

(727) 869-BONE (2663)
(727) 869-2660 FAX

In acknowledge and hereby consent to such, that the released information may contain alcohol drug initial abuse, psychiatric, HIV testing, HIV results, or AIDS information. Initial ____________

I hereby authorize the release of all necessary medical records to Katz Orthopaedic Institute for as long as I remain a patient there. I wish them to be forwarded as soon as possible. I, the undersigned, have read the above and authorized the staff of the disclosed facility named to disclose such information as herein contained I understand that this consent may be withdrawn by me at any time upon written notice except to the extent that action has been taken in reliance upon it I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Medical Information". This form must be received within 90 days of signing and is valid for 90 days after receipt.

Signature: ________________________________ Print Name: ______________________________

Relationship to patient: Self Parent Legal Guardian Grandparent Other

Signature of Witness: ________________________________ Date: ____________________