Rock

Orthopedic and Hand Center

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RELEASE OF MEDICAL INFORMATION

DATE:_____

PATIENT NAME:_____
PATIENT DATE OF BIRTH:_____

I, _____ hereby give my authorization to release my protected health information including my clinical documents, labs, xrays, and/or other test results to the following designated representatives.

_____Continued treatment with_____
_____Self
_____Spouse

Patient Signature/Legal Guardian_____
Date:_____