JEFFREY L. HALBRECHT, M.D., P.C.

Orthopedic Surgery & Sports Medicine

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Arthroscopic Surgery
Surgery of the Knee and Shoulder

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT'S NAME:_____

DOB:_____

ADDRESS:_____

PHONE NUMBER:_____

I hereby authorize_____ to release healthcare information to _____

THIS REQUEST AND AUTHORIZATION PERTAINS TO:

_____ALL HEALTHCARE INFORMATION

_____ALL RADIOLOGICAL STUDIES (X-RAY, MRI, BONE SCAN ETC…)

_____REPORTS

I HEREBY RELEASE THE ABOVE MENTIONED FACILITY AND IT'S STAFF FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THE ACT HEREBY AUTHORIZED.

I AGREE THAT ANY EXPENSE FOR THE ABOVE MENTIONED SERVICES SHALL BE MY RESPONSIBILITY.

_____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE