150 Southpark Blvd, Suite 102
St. Augustine, FL 32086
Phone: (904) 466-1197
Fax: (904) 823-8967

SPECIAL MEDICAL INFORMATION RELEASE FORM

I HEREBY AUTHORIZE **SPARTAN ORTHOPEDIC INSTITUTE** TO RELEASE MY MEDICAL RECORDS TO:

NAME: _____

ADDRESS: _____

ADDRESS CONT. _____

PHONE: _____ **FAX:** _____

Area of Body: _____

_____ Any information acquired in the course of examinations and/or treatment contained in my patient record.

_____ Xrays, including reports.

_____ Other: _____

I understand that a fee maybe charged for duplication of records and Xrays. Payment will be made prior to duplication.

I understand that this consent will remain in effect until revoked by myself in writing.

PATIENT'S NAME _____ DATE OF BIRTH: _____

PHONE: _____

_____

_____ _____
SIGNED DATE

GUARDIAN (If a minor): _____