475 West Town Place, Suite 106
St. Augustine, FL 32092
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): ______________________________