Upper Bucks Orthopaedic Association

Records Release Authorization Form

Patient Name:_____ Birth Date: _____

Date of request: _____

I give my consent to have Upper Bucks Orthopaedics release my medical information to: (Please provide the name of the recipient that will have permission to receive your medical information).

_____

When records are ready: ( ) Call me to pick up – (Tele #:) _____

( ) Fax to (Fax #:) _____

( ) Mail to: _____

_____

_____

_____ _____

Signature of Patient (or Patient's Legal Representative) Date

Relationship to Patient (or other authority)_____

Address: _____

_____ Tel#: _____

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