the center for BONE & JOINT SURGERY

Authorization for Examination of X-Ray and/or Medical Records

Today's Date: _____ / _____ / _____

Patient Name: *(Print First and Last)*_____

DOB: _____ / _____ / _____ **Account Number:** _____

Authorization

You may use or disclose the following health care information (check all that may apply.):

- ☐ X ray Films
- ☐ Medical Records
- ☐ MRI Films
- ☐ All
- ☐ Physical Therapy

Date(s) of Office Visit Request

Please list the date(s) of your visit(s) that you wish to have your records pulled from:

☐ Initial Visit to Present

_____ / _____ / _____ _____ / _____ / _____

_____ / _____ / _____ _____ / _____ / _____

Disclosure Information

Name *(Print First and Last):* _____

Address: _____

Fax: ( ) _____ - _____ **Fax Attn:** _____

Mailing Address: _____

I hereby release The Center for Bone and Joint Surgery from all legal responsibility or liability that may arise from this authorization.

_____ _____ / _____ / _____

Patient or Legally Authorized Signature Date

Harvey Montijo, M.D.
Garvin Yee, M.D.
Mark Waeltz, M.D.
Veronica Pedro, M.D.
Michael Mikolajczak, D.O.
Jose Ortega, M.D.
Jorge Acevedo, M.D.

Robert Lins, M.D.
Robert Rochman, M.D.
Nicholas Sama, M.D.
George M. Botelho, M.D.
David R. Simpson, M.D.
Laura E. White, M.D.
Dana Desser, D.O.