Full Circle ORTHOPEDICS

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FC ORTHO AUTHORIZATION TO DISCUSS HEALTH INFORMATION

Authorization to Discuss Health Information

I, _____ (patient name) would like to designate, _____

(Person authorized), my _____(relation), to discuss ALL medical care.

Authorized to Release Health Information

Patient's Name:

Date of Birth: | Last 4 digits of SSN:

I request to authorize_____ to release my records to my specialist, Please mail any imaging CD's to the address or fax above:

Signature of Patient:_____ **Date:**_____