Authorization to Release Records from:
Orthopaedic and Spine Center, LLC
1080 Polaris Parkway, Suite 200
Columbus, Ohio 43240
Telephone: 614-468-0300 Fax: 614-468-0214

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE TO PRIVACY PRACTICES

Patient Name: ___________________________ Date of Birth: ______________________

Authorization to Release Records

I hereby authorize and direct that the provider listed above release my medicals records including a report of patient diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to Patient's treatment, for the purpose of providing medical care to patient to:

Name of Provider: ____

Address: ____

____

Telephone: ____

Fax: ____

I understand that I have the right to inspect the information to be released.

I understand that I may revoke this authorization at any time by notifying the physician listed above in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Orthopaedic and Spine Center, LLC Notice of Privacy Practices.

Patient/Parent or Guardian Signature: ____

Today's Date: ___________________________