Stephen De Young, M.D.
ORTHOPEDIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _________________________ Date of Birth:__________
(Please Print)

I hereby authorize and request that the following medical records:

________ **All Medical Records**

________ **Records Dating** _________________ **to** __________________

________ **Other**

____

<u>To Be Released To:</u>

Name: ______________________________ **Phone: __________________**

Address: ____________________________ **Fax: ______________________**

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______________________________________ ______________________

Signature of Patient or Parent/Guardian **Date**

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