SOUTHWEST
Orthopedic Group, L.L.P.

Scott T. Orth, M.D.
ORTHOPEDIC SURGEON

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ______________________________ **Date of Birth:** __________________
(Please Print)

I, the undersigned, hereby authorize ______________________________ **to release medical records to:**

Name: ______________________________ **Phone:** ______________________

Address: ______________________________ **Fax:** ______________________

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To release the medical information described below: *(please check)*

________ **All Medical Records**

________ **Records Dating** ______________ **to** ________________

________ **Other** ____

____ ______________________________

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

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