

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request and authorize Broken Arrow Bone & Joint Specialists doctor or doctors to release medical information obtained in the course of my examination and treatment to all of the following:

- My primary and/or referring physician _____
- Myself
- Spouse
- Other _____

This authorization has been made voluntarily. Any information regarding my treatment or other condition that is not to be disclosed is specifically listed below and I will advise the treating Orthopaedic Surgeon of such request not to disclose certain information.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

Date

Patient's Name

Patient's Signature (Guardian, if minor)