Advanced Knee Care, PC.
A division of Integrated Orthopedics
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Release of Medical Records

Have your health information sent to another Provider

Date: ___/____/_____

Patient: _____ DOB:____/____/_____
Address: _____
SSN: _____ Phone: _____

Send to: *Name* _____

Street _____

City/State/Zip _____

email _____

Phone: _____ Fax: _____
Send the following information to above recipient :

Office notes: _____ Op Reports: _____ X-Ray reports: _____Lab reports: _____

By signing below, I hereby release Advanced Knee Care, its physicians and employees from any and all liability for fulfilling this authorized request for medical records/x -rays. This autho riza-tion includes ALL confidential information in my file, including HIV, communicable disease, alcohol/ drug abuse and genetic testing information. I understand that I may revoke this au-thorization at any time by notifying Advanced Knee care in writing.

THIS AUTHORIZATION WILL EXPIRE IN 1 YEAR AFTER SIGNED DATE.

Patient Signature: _____ Date: ____/____/_____