

Plancher Orthopaedics & Sports Medicine Medical Release Form

Last Name:

First Name:

Date of Birth:

Please check all that apply:

X-RAYS

MRI

EMG

REPORTS

BONE SCAN

CT SCAN

OTHER

LAB RESULTS

Please release medical records to:

Last Name:

First Name:

Company Name:

Address:

Medical records request will require a prepayment fee for copies. This authorization is good for 90 days from the date of signature. Photocopies and faxed copies of the form are valid.

Signature: _____

Date: _____

Acct#: