Medical Records

All Patients: Up-to-date information is essential for good medical care. Please supply the names of your doctors so that we can keep them informed.

Family Doctor / Internist or Pediatrician:

Doctor _____

City _____

Doctor _____

Specialty _____

City _____

Doctor _____

Speciality _____

City _____

Doctor _____

Speciality _____

City _____

Athletes: We will keep your coach informed for you!

Coach _____

Sport _____

School _____

City _____

Who referred you to this office?

☐ Doctor (name) _____

☐ Coach (name) _____

☐ Worker's Comp Carrier (name) _____

☐ HMO or PPO Book _____

Friend or Relative (name) _____

Other (name) _____

Athletic Trainer (name) _____

By signing, I understand that I hereby authorize the release of information to the above named parties and also understand that OrthoSurgeons will continue to release information until we are notified to end correspondence to the above named parties.

Your signature _____