DATE: __________

MEDICAL RECORDS AUTHORIZATION

PATIENT'S NAME: ____ DOB: ______________

TO WHOM IT MAY CONCERN REGARDING MEDICAL RECORDS AT:

____

(OFFICE OR FACILITY WHICH HOLDS RECORDS)

PLEASE FORWARD MY:

- ☐ COMPLETE MEDICAL RECORDS
- ☐ OPERATIVE NOTES
- ☐ OFFICE NOTES
- ☐ X-RAY DISC
- ☐ LAB REPORTS
- ☐ OTHER: ____

**For Pro Sports patients wishing to request physical copies of any diagnostic studies, please contact the facility that performed the service.*

I AM AUTHORIZING THE RELEASE OF MY MEDICAL RECORDS TO BE FORWARDED TO:

☐ **MYSELF :** Address: ____

☐ **OTHER:** ____

Phone: ______________________________ Fax: ______________________________

Address: ____

____

20 Guest Street, Suite 225 Phone: 617-738-8642
Brighton, MA 0213 Fax: 617-202-4172

____

PATIENT'S SIGNATURE
(OR ADULT WITH AUTHORITY TO ACT FOR MINOR)