Burton F. Elrod, MD
David R. Moore, MD
Jeffrey D. Willers, MD
Thomas T. Dovan, MD
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Chad T. Price, MD
Colin G. Crosby, MD
Gregory E. Raab, MD
Samuel N. Crosby, MD
A. Brian Thomson, MD
Amanda D. Martin, DO

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ________________________________ DOB:________________________

I request and authorize _____________________________________to release any and all information regarding my treatment to:

Name: ____
Address: ____
City: ________________________State: ________Zip: __________
Fax: _________________________Phone: ____________________

Check all that apply:

- Medical Records Only
- Itemized Billing Statement
- Imaging Disk (MRI, X-ray)
- Other ____
- All of the above

This authorization is valid for six (6) months from the date of execution.

Signature of Patient: _____________________________________Date: _____________________

Please email completed form to MedicalRecords@eliteorthopaedic.com