

35 Kennedy Drive
Putnam, CT 06260



THE CENTER
FOR BONE & JOINT CARE
ORTHOPEDIC ASSOCIATES OF WINDHAM COUNTY

5 Founders Street
Willimantic, CT 06226

Authorization for Release of Information

Name of Patient: _____

Date of Birth: _____ Phone #: _____

I authorize the Center for Bone & Joint Care to release the following records:

- Office Notes
- Operative Reports, Admit & Discharge Summaries, Consultation Reports
- X-ray Reports generated in this office
- X-ray Films (must sign additional authorization)
- Medical Correspondence and Reports

Restrictions: _____

Please be advised that our office policy requires us to forward only our own medical records. If you are requesting radiology, other diagnostic testing reports, or lab results, we will forward only those generated in this office. We ask that you kindly request these records from the facility at which the services were performed. Records copied for use by another medical provider and/or your insurance carrier are free of charge. Records copied for personal use or for your attorney are subject to a charge of 65¢ per page.

The above listed records are to be released to the following recipient:

The released information will be used for the following purposes:

In signing this release, I understand that The Center for Bone & Joint Care will not be held responsible for the disposition of the above noted records once released to the above recipient.

Signature _____ Date _____

If not signed by the patient, indicate relationship to the patient: _____