NEOS
NEW ENGLAND
ORTHOPEDIC SURGEONS

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME _____ **DATE OF BIRTH** _____

ADDRESS _____ **ACCOUNT NUMBER**_____

We have recently received a request to release medical information on the above referenced patient to the following party:

_____

_____

_____

Before we comply with this request, we require a signed release from the patient, guardian, parent (if patient is a minor), or executor of the patient's estate (if patient is deceased). Please read the following statement carefully, and sign and date where indicated.

I, _____, hereby authorize New England Orthopedic Surgeons, Inc., to release medical information, including but not limited to, office notes, operative notes, test results and reports, to the above-referenced requesting party.

This release shall be in effect for one year from the date of my signature below.

I understand that I may revoke this request at any time by written notice to New England Orthopedic Surgeons, Inc., except that this will not be retroactive to any information previously released in good faith.

SIGNED _____ **DATE** _____

RELATIONSHIP TO PATIENT _____