McKinley
Orthopedic & Sports Medicine

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____

I request and authorize McKinley Orthopedic and Sports Medicine to:

☐ RELEASE Information to:

☐ OBTAIN Information from:

Person or Business:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number _____ Fax Number _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient/Guardian Signature: _____ Date Signed: _____

THE PROCESSING TIME FOR MEDICAL RECORDS IS APPROXIMATELY 14 BUSINESS DAYS.

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED UNLESS REVOKE IN WRITING.

Timothy Carey, DO | Jennifer Malcom, DO | Gary Molk, DO | Kim Driftmier, MD
Tommie Younker, PA-C | Jennifer Holt, PA-C | Shannen McNamara, PA-C | Brianna Graham, NP | Robert Wood, PA
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