



**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
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**This request and authorization applies to:**

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.