



HANDSURGERY PC

REQUEST TO COPY PROTECTED HEALTH INFORMATION

By signing this authorization, I hereby authorize HandSurgery PC to release health information including copies of my medical records and/or X-rays to the following person(s) or class of persons at the location/facilities listed:

Persons/Class of Person _____

Location/Facility _____

Patient's Name: _____

Date of Birth: _____

Patient's Address:

Street Name and Number

City State Zip

Signature of Individual or Legal Representative:

Date: _____

Relationship of legal representative to individual: _____