

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION

All requests require 7-10 business days to complete.

By signing this authorization, I hereby authorize HandSurgery PC to release my health information including copies of all office notes and/or x-rays to the following as listed below.

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____
Street Name and Number

City State Zip

Telephone Number: _____

Please forward my office notes and/or x-rays to:

Name: _____

Address: _____
Street Name and Number

City State Zip

Telephone Number: _____

Signature of Individual or Legal Representative: Date: _____

Relationship of legal representative to individual if minor: _____

