

PA ORTHOPAEDIC CENTER
RUGGIERO ORTHOPAEDIC ASSOCIATES, LTD.
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MEDICAL RECORDS REQUEST

I, _____ do hereby authorize Ruggiero Orthopaedic Associates, Ltd. to release my medical records to me or my Authorized Representative, including office notes, test results, diagnosis, prognosis and/or treatment.

Date of request: _____

If mailing, where to?

Name _____

Address: _____

Phone #: _____

Patient's Signature

Date

Witness Signature

Date

Signature of Parent/Leal Guardian/Power of Attorney/
Authorized Representative

Date

For Office Use Only:

Date medical record was picked up/mailed: _____