New Jersey Center for Orthopedic and Sports Medicine
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AUTHORIZATION FOR RELEASE OF INFORMATION

I,________________________________ ______________________________ authorize the office of
(Patient/Responsible Party (DOB)

(please write your previous doctor's office information)

_________________________ ____________________________
Phone Fax

To release all information pertinent to the treatment of _________________________________ To

New Jersey Center for Orthopedic and Sports Medicine.
This information may include but not limited to: (Please check all that apply)

__ History and Physical
__ Office Notes
__ Radiology Report
__ Laboratory Results
__Operative Reports
__ Discharge Summaries
__ Other____

I Consent for the release with my signature

____ ____________
Patient/Responsible party Signature Date