DATE:_____

MEDICAL RECORDS AUTHORIZATION

PATIENT'S NAME:_____ DOB:_____

TO WHOM IT MAY CONCERN REGARDING MEDICAL RECORDS AT:

_____

(OFFICE OR FACILITY WHICH HOLDS RECORDS)

PLEASE FORWARD MY:

- ☐ COMPLETE MEDICAL RECORDS
- ☐ OPERATIVE NOTES
- ☐ OFFICE NOTES
- ☐ X-RAY DISC
- ☐ LAB REPORTS
- ☐ OTHER:_____

**For Pro Sports patients wishing to request physical copies of any diagnostic studies, please contact the facility that performed the service. If they were taken across the hall in our Brookline office, call 617-232-0420. Thank you.*

I AM AUTHORIZING THE RELEASE OF MY MEDICAL RECORDS TO BE FORWARDED TO:

☐ **MYSELF :** Address**:** _____

☐ **OTHER:** _____

Phone:_____ Fax:_____

Address: _____

_____

_____

PATIENT'S SIGNATURE

(OR ADULT WITH AUTHORITY TO ACT FOR MINOR)

20 Guest Street, Suite 225
Brighton, MA 0213
Phone: 617-588-3055
Fax: 617-202-4172