AUTHORIZATION TO RELEASE MEDICAL RECORDS

1014 W Park St Suite 4, Livingston, MT 59047
Phone: 406.222.4682 Fax: 406.222.4681

Patient Name:_____

Date of Birth:_____

I authorize_____ to release the following requested medical records of the patient named above to Granite Sports Medicine.

_____

_____

_____

_____

Please fax requested information to 406.222.4681

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____