

**LOUISVILLE BONE & JOINT SPECIALISTS, PSC**

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**RELEASE OF MEDICAL RECORDS**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Louisville Bone & Joint Specialists, PSC is hereby authorized to release my medical records and information pertaining to my medical care and treatment to:

Facility \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

If only specific records are being requested please complete:

\*\*Please send only records pertaining to my \_\_\_\_\_ (body part/injury). This injury occurred on or about \_\_\_\_\_ (date of injury).

Signed: \_\_\_\_\_  
(Parent or legal guardian if patient is a minor) Date

Printed Name: \_\_\_\_\_

LBJS use only:

Date Sent: \_\_\_\_\_ By: \_\_\_\_\_

Please check one:  Mail  Fax  Hand Delivery