

UNION COUNTY ORTHOAPEDIC GROUP

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DIPLOMATS OF THE AMERICAN BOARD OF ORTHOAPEDIC SURGERY TAX I.D. # 222-429-054
DIPLOMATES OF PHYSICAL MEDICINE AND REHABILITATION

Date: _____

RECORDS RELEASE

I hereby authorize and request Union County Orthopaedic Group to release the complete medical records in your possession concerning my illness and/or treatment from _____ - _____ to:

Physician's Name: _____

Address: _____

Phone#: _____

Fax#: _____

Signature : _____ Date: _____

(PATIENT/GUARDIAN OR NEAREST RELATIVE)