WOODS MILL ORTHOPEDICS, LTD
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SUITE 330S
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OFFICE: (314) 576-7013
FAX: (314) 576-4047

I, the undersigned, authorize the company and/or individual selected below to release my private health information.

- Woods Mill Orthopedics
- Dr. _____
  Address:_____
  Phone:_____ Fax:_____

Please forward my private health information to the selected company and/or individual selected below:

- Woods Mill Orthopedics
- Doctor or Individual_____
  Address:_____
  Phone:_____ Fax:_____

*Purpose of disclosure:_____

Information to be released:

Office Notes Consult Notes EKG/Cardiac Tests Lab Results Op Reports

Xrays (will be sent on a disc) Signed Orders Billing Records Other:

** A photocopy of this authorization is to be considered as valid as the original. The authorization is valid for 90 days from the date of signature. I understand that the information disclosed may be subject to re-disclosure by the company or individual receiving it, and would then no longer be protected by Federal Law.

Last Name, First Name and MI of Patient: _____
Patient's Full Address:_____
DOB:_____ Primary Contact Number:_____
Signature of Patient or Legal Representative:_____
Printed Name of Patient or Legal Representative:_____
Date Requested:_____