

**LOUISVILLE BONE & JOINT SPECIALISTS, PSC**

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**REQUEST FOR MEDICAL RECORDS  
TO LOUISVILLE BONE & JOINT SPECIALISTS, PSC**

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

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

The entity named below is hereby authorized to release my medical records and information pertaining to my medical care and treatment to **Louisville Bone & Joint Specialists, PSC.**

Facility \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

My appointment with Louisville Bone & Joint Specialists, PSC is:

\_\_\_\_\_

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

Date

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