



Orthopaedic Surgery

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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: _____