Surgery Center at Easton

3600 Stelzer Road, Suite 100
Columbus, Ohio 43219
Phone: 614-255-2900
Fax: 614-827-0874

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS to Orthopedic ONE Surgery Center at Easton

To whom it may concern:

I, _____, request the release of physician and/or hospital medical records to Orthopedic ONE Surgery Center at Easton.

I understand the information released will be used for the purpose of determining my care and will become a part of my permanent record. I authorize those portion(s) of my record deemed necessary by the physician caring for me to be faxed/mailed to the facility.

The undersigned hereby releases the above-mentioned from any liability that may arise from release and/or examination of the information indicated above.

Patient to Complete:

_____
Patient Name

_____ Date of Birth: _____/_____/_____
Patient Address

_____ Date Signed: _____/_____/_____
Patient Signature

Witness to Complete:

_____ Date Signed: _____/_____/_____
Witness Signature