authorization to obtain medical records

Christopher J. Lenarz, MD

17300 N Outer 40 Road, Suite 316, Chesterfield, Missouri 63005
Phone: (636) 778-3177 Fax: (314) 309-2551

---

patient name	date of birth
address	social security number

I request and authorize **EXCEL ORTHOPEDICS** to obtain the healthcare info as stated below from:

name		phone number
address		fax number
city	state	zip code

This request and authorization applies to

healthcare information relating to the following treatment, condition, or dates

all healthcare information / other

I permit the release of all information indicated above including, if any, information concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV or other communicable diseases test results, and/or diagnosis and treatment.

I understand that this authorization will expire one (1) year from the date listed below.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, except to the extent the organization has taken action in reliance on the consent.

I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

relationship of representative to patient	date