authorization to release healthcare information

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patient name	date of birth
address	social security number

I request and authorize EXCEL ORTHOPEDICS to release healthcare information of the patient named above to

name

address		date
city	state	zip code

This 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.

patient signature	date signed