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# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ______________________________ Date of Birth: ______________

I hereby grant Premier Orthopaedics & Sports Medicine, P.C., and/or Spine and Trauma Institute(STI), and/or Advanced Center for Excellence in Spine Surgery(ACES), and/or Hand and Trauma Institute (HTI), authorization to access and procure all of my medical records and history for purposes of insurance, legal, or medical care related to the treatments rendered by their personnel, providers, or representatives. I acknowledge that this is my choice, and I can withdraw my authorization at any time by providing a written and signed communication unless action has already been taken based on this consent.

______________________________ ______________

Client Signature Date