CAPSTONE
ORTHOPEDICS & SPORTS MEDICINE

MEDICAL RECORDS RELEASE

Please forward this completed form to **ALL** physicians who have treated you for this, or a related condition.

TO: Physician name:_____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

I hereby authorize you to release to:

CAPSTONE ORTHOPEDICS & SPORTS MEDICINE, LLC
1818 E 23rd Avenue
Hutchinson KS 67502
Telephone: (620) 259-2325
Fax: (620) 259-2337

Information from my Medical Record including (check one):

☐ Information for my Medical records for all dates of service
☐ Information from my Medical Record during the period _____ to _____

For the purposes of release of medical records information, a photocopy or facsimile copy of my signature may be considered as acceptable, legal and binding as my original signature. This release is valid for a period of six months from the date written below:

By: _____
Signature of patient, guardian or authorized representative Date

Witness: _____

PATIENT INFORMATION (please print):

Patient Name: _____

Address: _____

City, State, Zip :_____

Date of Birth: _____

Social Security Number: _____