CAPSTONE
ORTHOPEDICS & SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____
Date of Birth ____/____/____
Social Security number _____-_____-_____
Address: _____
_____
_____
Telephone Number (_____) _____-_____

Please release all my medical records for the following date(s) of service (Check one):

☐ All Dates of Service
☐ From _____ to _____
Date Date

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

TO: _____
_____
_____
_____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ _____
Patient Signature Patient Representative Signature

_____ _____
Printed Name Printed Name and Relationship

Date: _____

FOR CAPSTONE ORTHOPEDICS & SPORTS MEDICINE USE:
Received by: _____ (Employee / Dept)
MR #: _____ Provider: _____