David N. Buchalter, M.D.
SPORTS MEDICINE
JOINT RECONSTRUCTION
ARTHROSCOPIC SURGERY

Steve Meadows, M.D.
SHOULDER/ELBOW SURGERY
WRIST/HAND SURGERY
FRACTURE REPAIR/
RECONSTRUCTION

Russell D. Weisz, M.D.
ORTHOPEDIC SURGERY
TRAUMA/FRACTURE SURGERY
POST-TRAUMATIC
RECONSTRUCTION

Jonathan M. Tarrash, M.D.
PHYSICAL MEDICINE &
PAIN MANAGEMENT

CONSENT TO RELEASE/OBTAIN PATIENT RECORDS

I hereby authorize South Palm Orthopedics

_____ To RELEASE copies of my medical records to:

_____ To RECEIVE copies of my medical records from:

NAME _____

ADDRESS _____

PHONE _____ **Fax** _____

I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be released.

_____ Send all of my records
_____ Send only the following records

I understand that payment is to be made in full before my records will be released.

Signature _____ ***Date*** _____

Patient's Printed Name _____

SS# _____ **Date of Birth** _____

Patient's Address _____
