TRI COUNTY ORTHOPEDICS, P.C.

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Farmington Hills, MI 48336-5969
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GENERAL ORTHOPEDICS ° SPORTS MEDICINE ° JOINT RECONSTRUCTION ° HAND SURGERY
ARTHROSCOPIC SURGERY ° TRAUMATOLOGY

HOMER C. LINARD III, D.O., F. A. O. A. O. JACK D. LENNOX, D.O., F.A.O.A.O.

Record Release Authorization

Name: _____ Date of Birth: _____
Phone: _____ Social Security Number: _____
Address: _____ City, Sate, Zip: _____

From: Tri County Orthopedics, P.C.
Jack D. Lennox, D.O. / Homer C. Linard, D.O.
28100 Grand River, Suite 209
Farmington Hills, MI, 48336

Treatment date: _____ to _____ or _____ ALL RECORDS
The purpose of disclosure is: (please check all that apply)
> Change of Insurance or Physician > Continuation of Care > Referral ALL X-RAYS
> Other: _____

Release to: _____ > Please mail records
Address: _____ > Please fax records
City, State, and Zip: _____ >Please hold for pickup
Fax: _____ Phone: _____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date requested unless other dates are specified.
I understand the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand I may revoke this authorization at any time. I understand that if I revoke authorization I must do so in writing and present my written revocation to the management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my police. **Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify and expiration date, event, or condition, this authorization will expire one year from the signed date.**

Signature: _____ Date: _____

If guardian or DPOA, state relationship: _____

Initials: Date: