



# TRI COUNTY ORTHOPEDICS, P.C.

28100 Grand River, Suite 209  
Farmington Hills, MI 48336-5969  
(248) 474-5575

Fax (248) 474-4679  
<http://www.tricountyorthopedics.com>

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

I hereby authorize and request release of my records from: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Treatment date: \_\_\_\_\_ to \_\_\_\_\_ or \_\_\_\_\_ ALL RECORDS

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

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 policy. **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: \_\_\_\_\_