

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

I do hereby authorize Ozark Surgical Group to provide copies of any and all of my medical records deemed necessary for my treatment, to any physician or medical facility or to others that may be affiliated with my treatment including, but not limited to, insurance companies, workers compensation carriers, and State or Federal agencies with whom I may have applied for medical assistance.

A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name:

Person authorized to sign for patient:

Print

Print or Type Name

X

Patient's Signature

Signature

Date

Relationship to Patient

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I do hereby authorize _____ to provide in

writing to **Ozark Surgical Group, 901 Burnett Drive, Mountain Home, AR 72653 Fax 870-424-7666**

a report of my diagnosis, treatment, prognosis and recommendations as well as other data pertinent to my

treatment during the period from: all dates _____ to _____.

Specific records requested _____

A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name:

Print

Date of Birth

X

Patient's Signature

SSN

Date