Orthopaedic Institute of Southern Illinois

Medical Records Release to Orthopaedic Institute of Southern Illinois

Last Name: ______________________________ First Name: ________________________ MI: _______

Street Address: ____

City: ________________________ State: _______________________ Zip: ________________________

Telephone: __________________ Date of Birth: ________________ SSN: _______________________

I have been a patient at Orthopaedic Institute of Southern Illinois under the care of:

Doctor: _______________________________________

With my signature, I am hereby authorizing ____
Medical Institution Name

to release my records including:

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Send/Fax all requested records to:

Orthopaedic Institute of Southern Illinois
510 Lincoln Drive
Herrin IL 62948
(618) 997.6800
(618) 998-9124 (fax)

I understand that I may cancel this authorization at any time except when the above information has already been released in accordance with this authorization. This authorization is void within 60 days from the date of signature. I further hereby certify that I understand the nature of this release. Please also note that the Orthopaedic Institute of Southern Illinois will not photocopy any material that was not originated in our facility.

____ ____________________________

Signature of Patient or Guardian *Date*