



PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS TO TRISTATE

I, _____, request that _____
release my protected health information to Tristate Orthopaedic Treatment Center for
purposes of patient care.

The information I am requesting be sent to Tristate includes (please check item
desired):

- _____ Entire medical record
- _____ Medical Record during the period from _____ to _____
Date Date
- _____ X-rays

Information is to be sent to (mark location):

- _____ 10547 Montgomery Rd, Suite 400, Cincinnati, OH 45242
- _____ 4600 Smith Rd, Suite 400, Cincinnati, OH 45212

This authorization shall expire one (1) year from the date signed.

Print Patient Name

Date of Birth

Patient or Authorized Representative Signature

Date