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REQUEST FOR MEDICAL RECORDS
TO LOUISVILLE BONE & JOINT SPECIALISTS, PSC

Patient Name: ____

Date of Birth: ____

The entity named below is hereby authorized to release my medical records and information pertaining to my medical care and treatment to **Louisville Bone & Joint Specialists, PSC.**

Facility ____

Address ____

____

Phone ______________________

My appointment with Louisville Bone & Joint Specialists, PSC is:

____

Signed: ____
(Parent or legal guardian if patient is a minor)
Date
Printed Name: ____