The Centers for Advanced Orthopaedics
Anne Arundel Orthopaedic Surgeons

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MEDICAL RECORDS RELEASE REQUEST TO BE FORWARDED TO ANNE ARUNDEL ORTHOPAEDIC SURGEONS

Date: _____

To: _____

Address: _____

Fax: _____

I hereby authorize you to release to:

_____, M.D.
Centers for Advanced Orthopaedics
Anne Arundel Orthopaedic Surgeons
2003 Medical Parkway, Suite 400
Annapolis, MD 21401
Phone: 410.573.2530 Fax: 410.573.2536

All information including the diagnosis and records of examination or treatment rendered to me during the period from _____ to _____.

Specific reports requested as follows: _____

_____

_____ _____
Signature of Patient Witness
or Parent/Legal Guardian, if minor

Printed Name of Patient: _____ DOB: _____

Patient's Social Security No.: _____

Rev. 091417