

CONTENTS ARE CONFIDENTIAL. SEE NOTE BELOW.

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
(Physician Name)

Fax Number: _____

I authorize the above named provider to disclose and deliver to Steindler Orthopedic Clinic the following information:

_____ Name of Patient	_____ Date of Birth
_____ Patient or Authorized Representative Signature	_____ Date (Expires 30 Days After Signature)

If signed by Patient Representative, state authority to act on behalf of patient:

Please fax to Steindler Orthopedic Clinic at (319) 338-0522.

If you have any questions regarding this request, please call us at (319) 338-3606.

The documents accompanying this transmission contain confidential information belonging to the sender and are legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this telecopy information is strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone to arrange for the return of the original documents to us.