*Providing state of the art orthopedic care in a friendly environment*
2305 Genoa Business Park Dr., Suite 170, Brighton, MI 48114
**Tel: 810-299-8550 Fax: 810-844-0837 www.advancedortho.net**

**Laith Farjo, M.D.** **Matthew Caid, D.O.** **Robert Mihalich, M.D.**
**Michael Peters, PA-C Chris Stuart, PA-C** **Alyssa Zantello, PA-C**

# Authorization for Release of Medical Information

Patient Name: ______________________________________________

Guardian Name: ______________________________________________
(if applicable)
Date of Birth: ________________ Contact Number: ______________________

I, ______________________________, authorize Advanced Orthopedic
(Patient or Legal Guardian Name)
Specialists to (circle one) RELEASE or OBTAIN:

_____ Progress Notes
_____ MRI/CT/US Report
_____ Lab Results
_____ X-Ray's
_____ Disc ($10 charge)
_____ Paper (no charge)*unable to fax

_____ Operative Report
_____ Itemized Bills
_____ All Information
_____ Other: ___________________
________________________________
________________________________

Regarding: RIGHT LEFT Bilateral (circle one)
___Shoulder ___Elbow ___Wrist ___Hip ___Knee ___Ankle ___Foot

To: (circle one) MYSELF or GUARDIAN or PHYSICIAN:
Name: ____________________________________________________________

____________________________________________________________
(Pick up / Fax/ Mail)

____________________________________________________________
(Fax Number / Phone Number / Address)

***Please allow 7-10 business days for processing

______________________________ ________________
Patient / Legal Guardian Signature Date

______________________________ ________________
Witness Signature Date

**This authorization will expire six months after the date of request**