ORTHOPEDIC SURGERY & SPORTS MEDICINE

Steven Porter, MD, PC

4566 E Inverness Ave #108
Mesa, AZ 85206
Phone: 480-659-4811
Fax: 480-659-4629

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name:____ DOB:________________________

Address:____

SSN:____________________________________ Phone#____________________________________

I hereby authorize the release of me medical records to Orthopedic Surgery & Sports Medicine.

My treating physician is: **Dr. Steven Porter**

Information needed:
( ) Healthcare information relating to the following treatment, condition, or dates of treatment.

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( ) All Healthcare information

( ) X-Rays

( ) Other:____

Patient Signature:____ Date:______________________________