



**NON-SURGICAL
ORTHOPAEDICS, P.C.**
Specializing in Spine Care & Pain Management

Arnold J. Weil, M.D.
Anthony R. Grasso, M.D.

Medical Records Release

Date: _____

Patients Name: _____

Patients SSN: _____

Patients DOB: ____ / ____ / ____ (MM/DD/YYYY)

Patients Phone #: _____ - _____

I, _____, authorize the release of my medical records and request that they be sent to:

Non-Surgical Orthopaedics, PC
335 Roselane Street
Marietta, GA 30060
Fax 770-421-8055 ATTN: Medical Records

There is no expiration date for this authorization unless noted and initialed below:

Expiration date: _____ Patient Initials _____

I understand that I have the right to revoke this authorization at any time. I must do so by writing Non-Surgical Orthopaedics, P.C. The revocation will not apply to information that has already been released in response to this authorization.

Patient/ Guardian Signature

Date

Relationship if not patient

Witness

Date