

FAIR OAKS ORTHOPAEDIC ASSOCIATES, INC.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name _____ *Date of birth:* _____

PERSONS/ORGANIZATIONS RECEIVING THE INFORMATION

SPECIFIC DESCRIPTION OF INFORMATION TO BE SENT:

PATIENT/GUARDIAN SIGNATURE:

_____ *date* _____

Please send this information to the office at your earliest convenience. The fax number is 703-391-2945 and our office phone number is 703-391-0111. Thank You.