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Diplomate American Board of Orthopedic Surgery

DATE: _____

TO: NAME: _____
Last First Title

_____
Address/City/State/Zip

_____
Telephone Fax

I hereby authorize and request you to release to/from:

Paul M. Puziss, M.D., P.C.
3800 SW Cedar Hills Blvd., Suite 250
Beaverton, OR 97005
503-646-8995
Fax 503-644-4678

The complete x-rays and medical records in your possession concerning my illness and/or treatment during the period from: (check appropriate choice)

_____ From: _____ To: _____

_____ Chart Notes Dates From: _____ To: _____

_____ Films and/or reports of X-RAY / MRI only

Other: _____

SIGNED _____
Patient or guardian

PRINTED NAME _____

DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____

WITNESS _____