

WOODFIELD ORTHOPAEDICS & SPORTS MEDICINE, LTD

1102 S. ROSELLE RD.

SCHAUMBURG, IL 60193

847/301-7773 Fax 847/301-6506

RELEASE OF MEDICAL RECORDS

Date: _____

I, _____ do hereby authorize the release
of any and all medical records from _____

to **Woodfield Orthopaedics & Sports Medicine, Ltd., 1102 S. Roselle Rd., Schaumburg, IL
60193**

Please release the following:

Medical Records/Progress notes _____

Operative Reports

Imaging Studies (XR, MRI, CT, Bone Scan) _____

Test/Lab results (EMG, etc) _____

Other (Video, Pictures, etc) _____

This includes diagnosis and treatment rendered to:

(patient's name)

(signature)

(relationship to patient if minor)