Town Center
ORTHOPAEDICS

REQUEST TO RELEASE MEDICAL INFORMATION TO TOWN CENTER ORTHOPAEDIC ASSOCIATES

Date: _____

Name of Patient: _____

DOB: _____

I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO TOWN CENTER ORTHOPAEDIC ASSOCIATES

_____

(Signature of Patient)

Please fax records to: 703-662-4506

Town Center
ORTHOPAEDICS

ASHBURN ▪ CENTREVILLE ▪ FAIRFAX ▪ RESTON

1860 Town Center Drive, Suite 300 ▪ Reston, Virginia ▪ 20190 ▪ **P** 703.435.6604 ▪ **F** 703.662.4506 ▪ TOWNCENTER**ORTHO**.COM

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