PAUL A. DOWDY, M.D.
Orthopedic Center for Sports Medicine

Authorization for the Release of Medical Records
*****Must Present Photo ID of Patient*****

Patient's Name: _____ **DOB:** _____

Requesting records from:

Doctor/Facility Name: _____

Address: _____

City, State, Zip Code: _____

Release records to: _____

Doctor/Facility Name: _____

Address: _____

City, State, Zip Code: _____

Please release any/all information including diagnosis, examination, and treatment unless specified otherwise below.

Treated for: _____

Dates of Service: _____

_____ _____

Signature **DOB**

_____ **Photo ID Verified:**_____

Witness