NON-SURGICAL ORTHOPAEDICS, P.C.
Specializing in Spine Care & Pain Management

Arnold J. Weil, M.D.
Anthony R. Grasso, M.D.

Date: _____

Patient Name (please print): _____

Patient Date of Birth: _____ (MM/DD/YYYY)

Patient Social Security # _____ (xxx-xx-xxxx)

Patient's Phone #: (_____) _____

I authorize Non-Surgical Orthopaedics, PC to release my medical information to:

Name of Practice / Doctor / Person: _____

Address: _____

_____

Phone #: (_____) _____

Fax #: (_____) _____

What records would you like sent: (**choose one**)

☐ **Most Recent**
☐ **Entire**
☐ **Other / Specific:** _____

Please be aware that Non-Surgical Orthopaedics, PC requires a minimum of 72 hours to process records. With authorization, records may be faxed in emergency situations only.

Do you want to pick up the records? If yes, what date: _____

Patient Signature: _____

I understand that by signing above, I authorize Non-Surgical Orthopaedics, PC and The Center for Spine Procedures to release any medical or personal information requested. I have read the Practice Policy Book and will be bound by the provisions contained therein, including all rights under HIPAA.