VERGHESE ORTHOPEDICS

Vergheseorthopedics@gmail.com Fax 815 802 8044

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Dr George B Verghese MD of 656 N Convent St, Suite A. Bourbonnais. IL 60914

To email my medical records to (Physician or person’s name)……………………………………………………………

Email address……………………………………. …………………………………………………………………………………………….

(emailing via encrypted records Athena.com with is the preferred method. A password will be sent to you by separate email).

Or Fax to ……………………………………………………………………………………………………………………………….

(Documents will be faxed by secure Athena fax. Security at Receiving End is NOT guaranteed ).

The release applies to all pertinent medical records including but not limited to Progress notes, Xray interpretations, as well possibly copies of lab results and and diagnostic tests and/or consultations.

PATIENT NAME-……………………………………………………………………………………………………………………..

Date of Birth-…………………………………………………………………………………

Address---………………………………………………………………………………………………………………………………...

 ……………………………………………………………………………………………………………………………………….

Contact phone number-………………………………………………………………………………………………………

Email address-……………………………………………………………………………………………………………………

Patient signature- Date-

Witness signature- Date-