



**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, the undersigned, hereby authorize \_\_\_\_\_  
To release all information from my medical records for the following dates of service:

\_\_\_\_\_ thru \_\_\_\_\_.

Please include all clinical notes, operative records, discharge summaries, x-ray reports, and/or actual films. Should you have difficulty finding this patient, please contact this office for further information to helping processing this request.

The above information should be released to:

Dubin Orthopaedic Center, P.S.C.  
Ronald S. Dubin, M.D.  
P.O. Box 220  
Middlesboro, KY 40965

Phone: (606)248-0050  
Fax: (606)248-8711

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of patient or legal guardian:

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Thank You for your assistance.

Dubin Orthopaedic Centre, P.S.C.