



**AUTHORIZATION FOR RELEASE OF INFORMATION TO  
ALLIANCE ORTHOPAEDICS & SPORTS MEDICINE**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, the undersigned patient/guardian, hereby the release of protected health information from the medical records of:

Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_

SSN: \_\_\_\_\_

**Party To Whom Records Should Be Sent:**

Alliance Orthopaedics & Sports Medicine  
5040 Snapfinger Woods Drive Suite 206  
Decatur, Georgia 30035  
Fax: (770)322-1133

**This authorization for Release of Information is in force:**

\_\_\_\_\_ until revoked by me in writing or

\_\_\_\_\_ until \_\_\_\_\_ (Date)

**I further authorize that a copy of this medical authorization may be used in lieu of the original.**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

5040 Snapfinger Woods Drive Suite 206  
Decatur, Georgia 30035  
(770)322-7333