The Christ Hospital
ORTHOPAEDIC ASSOCIATES
Freiberg Orthopaedics
and Sports Medicine

Specializing in:
Arthroscopic Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Pediatric Orthopaedics
Reconstructive Surgery
Scoliosis
Sports Medicine
Total Joint Replacement
Trauma / Fractures

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Western Hills
Mt. Airy

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www.freibergortho.com

FOUNDED IN 1890
Entering our third century of excellent Orthopaedic care.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize:

____
Name

____
Address

to release to:

Freiberg Orthopaedics & Sports Medicine
4380 Malsbary Rd, Ste 200
Cincinnati, OH 45242
Fax: (513) 221-1962

a copy of my (or give relationship________________________) medical records or other information regarding my treatment, hospitalization, and/or outpatient care, including psychiatric/psychological conditions, drug or alcohol abuse, drug-related conditions, alcoholism, HIV testing or treatment of AIDS and AIDS-related conditions. The following information is being requested:

- ☐ copies of office notes for dates of service from __________ to ____________.
- ☐ copies of x-rays

The above information is requested to be released to assist in my medical treatment.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the above treatment records.

____
Patient's Name (Please Print) Maiden Name (if applicable)

____
Address

____
Birthdate

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Other person legally authorized to give consent Witness

____
Relationship to patient and reason