

*STEINGART ORTHOPEDICS, P.C.*

*MICHAEL A. STEINGART, D.O.*

ORTHOPEDIC SURGERY • BOARD CERTIFIED

16601 North 40th Street, Suite 210, Phoenix, AZ 85032

602-923-8500, 602-923-8502 fax

**MEDICAL RECORDS RELEASE**

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

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

Date of birth: \_\_\_\_\_

I authorize Steingard Orthopedics, PC to release my records to/obtain my records from \_\_\_\_\_.

Patient Signature \_\_\_\_\_

Witness \_\_\_\_\_