ALLEGIANCE ORTHOPEDIC AND SPINE INSTITUTE, PLLC

PHONE: (561) 409-9309
FAX: (561) 431-8184
EMAIL: Allegianceosi@gmail.com

101 NW 1ST AVE
SUITE B
DELRAY BEACH, FL 33444

Record Release Authorization

PATIENT'S NAME: ____

ACCT#:____

DATE OF BIRTH: ____

PATIENT SIGNATURE: ______________________________________

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORDS TO:

Allegiance Orthopedic and Spine Institute, PLLC

PLEASE FAX BACK TO THE OFFICE BELOW:

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