

**HAMPSHIRE ORTHOPEDICS AND SPORTS MEDICINE, INC.**

4 West Street - West Hatfield, MA 01088  
(Tel) 413-586-8200 - (Fax) 413-582-1460  
[www.hampshireorthopedics.com](http://www.hampshireorthopedics.com)

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**PATIENTS NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

We have recently received a request to release medical information on the above referenced patient to the following party:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Before we comply with this request, we require a signed release from the patient, guardian, parent (if patient is a minor), or executor of the patient's estate (if patient is deceased). Please read the following statement carefully, and sign and date where indicated.

I, \_\_\_\_\_, hereby authorize Hampshire Orthopedics and Sports Medicine, Inc. to release medical information, including but not limited to, office notes, operative notes, test results and reports, to the above-referenced requesting party.

I understand that I may revoke this request at any time by written notice to Hampshire Orthopedics and Sports Medicine, Inc., except that this will not be retroactive to any information previously released in good faith.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

**RELATIONSHIP TO PATIENT** \_\_\_\_\_

**HAMPSHIRE ORTHOPEDICS AND SPORTS MEDICINE, INC.**

4 West Street - West Hatfield, MA 01088

(Tel) 413-485-6119 - (Fax) 413-485-6169

[www.hampshireorthopedics.com](http://www.hampshireorthopedics.com)

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

To Whom It May Concern:

Please release the following medical information to the above.

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Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_