



Dr. H. Kurtis Biggs, D.O.

Fellowship Trained Joint Replacement Surgeon
Board Certified Orthopedic Surgeon

Medical Record Release Authorization

Date: _____

Patient Name: _____ DOB: _____ SS# _____

I Hereby authorize: _____

To release copies of the following:

- Medical Records Medical Records and X-Rays X-Rays
- Psych Eval HIV/AIDS Treatment Hepatitis C Testing
- Alcohol/Drug Abuse Eval

To: Dr. H. Kurtis Biggs D.O.

Purpose of Release: Continuing Care Insurance Litigation Personal

This Authorization expires on the following date: _____ (If no date is specified, this release expires one year from today's date.)

I understand there will be a \$10.00 charge for x-rays and I agree to pay for the copies at the time of pickup.

Patient Signature
