



K Valley Orthopedics, P.C.

Southwestern Michigan Sportsmedicine Clinic

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I HEREBY AUTHORIZE K VALLEY ORTHOPEDICS, P.C.
SOUTHWESTERN MICHIGAN SPORTSMEDICINE CLINIC
AND, OR, DR. _____
TO RELEASE TO: _____

ALL RECORDS AND / OR X-RAYS IN YOUR POSSESSION CONCERNING
MY _____ DIAGNOSIS, EXAMINATION, AND TREATMENT
DURING THE PERIOD FROM _____ TO _____

PRINT NAME _____ PHONE (____) _____

DATE OF BIRTH ____/____/____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SIGNATURE _____ DATE _____

IF RELATIVE, STATE RELATIONSHIP OR P.O.A. _____

WITNESS _____ DATE _____

A COPY OF MY SIGNATURE WILL SERVE AS AN ORIGINAL.

FOR OFFICE USE ONLY

DATE SENT ____/____/____