MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____
Address: _____
Social Security: _____

I, _____, patient of Dr. David Loncarich, an authorizing Fondren Orthopedic Group, L. L.P., located at 7401 South Main, Houston, Texas, 77030, to release records pertaining to the above. Disclosure may include any and all medical or billing records including information regarding diagnosis, test results, and treatment of drug, alcohol, substance abuse, AIDS or psychiatric disorders, and stamped materials prohibiting re-disclosure.

These records are to be released to:
Name: _____
Company: _____
Address: _____
Telephone: _____
Fax #: _____

These records are being requested for the purpose of:
_____
_____
_____

For the date(s) of treatment: From_____ through_____

Fondren Orthopedic Group, L.L.P., its employees and the officers and physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

This authorization will expire 180 days from the date signed. This authorization may be revoked at any time, but not retroactive to release of information in good faith.

Signed: _____ Date: _____

Relationship: _____ Witness: _____