SOUTHWEST
Orthopedic Group, L.L.P.

Stephen De Young, M.D.
ORTHOPEDIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth:_____
(Please Print)

I hereby authorize and request that the following medical records:

_____ All Medical Records

_____ Records Dating _____ to _____

_____ Other

_____

To Be Released To:

Stephen De Young, M.D.
16659 Southwest Freeway, Suite 321
Sugar Land, Texas 77479
Phone: (281) 494-1314
Fax: (281) 494-1346

_____ _____
Signature of Patient or Parent/Guardian **Date**