Medical Release Authorization

You are authorized and directed to furnish any and all information requested pertaining to my medical care and treatment to:

Dominion Orthopaedic Clinic, LLC

John I. Foster, III, M.D., FACS

William G. Sutlive, III, M.D.

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This authorization includes furnishing of the originals or copies of all charts, summaries, test results and all other written memoranda or data including x-rays and photographs.

Date Of Birth*_____

Signature*_____

Todays Date*_____