

**W. Bradley White, MD
Shawn P. Harrington, MD**

**Ronald E. Michalak, MD
Nicolas C. Zafiroglu, PA-C**

Release of Medical Information

Patient's Name: _____ **DOB:** _____

I hereby authorize: **Monadnock Orthopaedic Associates, PLLC**
458 Old Street Road, Ste 200
Peterborough, NH 03452

to release protected patient information it has in its possession regarding treatment, examination, and/or diagnosis rendered unto me. Please forward copies to:

I am especially interested in the following information:

- ___ Initial Office Evaluation
- ___ Operative Notes
- ___ Pages of implant stickers for total joint procedures
- ___ Office notes
- ___ Final Office Evaluation
- ___ Diagnostic Studies: (Films MRI EMG/NCV Labs Other:_____)
- ___ Arthroscopic photos
- ___ Other: _____

Date of Service Include: _____

Signature of Patient/Authorized Representative

Date

Signature of Witness

Date