

ARTHRITIS & OSTEOPOROSIS CENTER OF KY  
789 EASTERN BYPASS  
BLDG. #1 STE #17  
RICHMOND, KY 40475  
PHONE: (859) 623-5500 / 1-888-422-6360  
FAX: (859) 625-5007

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Date: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to furnish information related to my hospitalization/or treatment during the period of \_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature and relationship of next of kin if patient is a minor or mentally incompetent.