William T. Long, M.D.
2200 West Third Street, Suite 400
Los Angeles, CA 90057
(213) 484-7600

PHYSICIAN REFERRAL RECORD

Patient Name: _____
First MI Last

Patient Date of Birth: _____ Patient Age: _____ Sex _____

Social Security Number: _____

Were you referred to us by: ☐ Primary care ☐ Orthopaedic surgeon ☐ Other practitioner
☐ Family/Friend or Other _____

If yes, please give us the name and mailing address:

Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ Fax: _____

Would you like your medical records from this clinic released to any other person or physician:

☐ Yes ☐ No

Name: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ Fax: _____

AUTHORIZATION TO RELEASE INFORMATION TO REFERRING/PRIMARY CARE/ORTHOPAEDIC SURGEON(S) /OTHER

I hereby authorize William T. Long, M.D. to release medical information regarding my treatment to the physician(s) or other individual listed above for purposes of continuing evaluation of treatment.

_____
Patient/Patient Representative Signature Date Signed/Time Relationship to Patient