

**CYPRESS CREEK ORTHOPEDICS & SPORTS MEDICINE  
RICHARD A. SCHRAM, M.D., PA**

\_\_\_\_\_  
Patient Name (please print)

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

**RELEASE OF INFORMATION**

**Cypress Creek Orthopedics & Sports Medicine is hereby authorized to furnish medical information as may be necessary for the payment of all charges by my insurance carrier, Medicare, Medicaid, or any other payor or agency, from the medical records compiled during the duration of my care. This waiver also authorizes release of copies of my medical records to healthcare practitioners and organizations who are involved in my continued care. Cypress Creek Orthopedics & Sports Medicine will only release my healthcare information as specified by state law. I understand that I have the right to obtain copies of my healthcare information for a fee.**

\_\_\_\_\_  
Patient/Authorized Representative's Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Office Staff

\_\_\_\_\_  
Date