The ORTHOPEDIC CENTER OF ST. LOUIS

Brett A. Taylor, M.D.

Date: ____/____/____

To: _____

_____

I authorize and request you to release my medical records to:

Brett Taylor MD
The Orthopedic Center of St. Louis
14825 N Outer Forty Road, Suite 200
Chesterfield, MO 63017
ATTN: Lori Burke
Phone: 314-336-2555
Fax: 314-336-2654

Please send:

____ Complete medical record

____ Office notes

____ Operative Report (spine only)

____ X-Ray reports (spine only)

____ X-Ray films to include MRI, CT, CT Myelogram, Discogram

Patient name: _____

Date of birth: ____/____/____

Signed: _____

Printed: _____