West/Central Location:
1225 E. Cliff Dr, 2-A
El Paso, TX 79902
Ph: 915-598-3338
Fax: 915-598-3339
www.charlespittledpm.com

charlespittle
DPM, PLLC.

Eastside Location:
10500 Vista del Sol Dr, A
El Paso, TX 79925
Ph: 915-598-3338
Fax: 915-598-3339
info@charlespittledpm.com

Patient Authorization to Release Medical Record

Patient's name: ______________________________

Patient's Date of Birth: ______________________ Patient SSN #: ______________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone #: ______________________ Alternate Phone #: ______________________

I, ______________________________, do hereby authorize any health care provider or entity who has provided health care to me, or my dependent, to provide the Podiatrist, Doctor, Medical Professional or other entity as designated below, or its authorized representatives, any and all information relevant to me, or my dependent's medical condition, all treatment and billing records, including, but not limited to patient records, medical charts, test results, billing and payment records, insurance correspondence, evaluations, x-rays or other diagnostic tools, prescriptions, progress notes, history and physicals, order sheets, admission forms, laboratory reports, hospital records, incident reports and consultation records, for the purpose of my, or my dependent's, continuing care.

Further, if applicable, I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.

[Please circle a doctor or write in the information where your information is to be sent]

Dr. Charles I. Pittle, DPM	Dr. Alan W. Pittle, DPM	Name: ______________________
1225 East Cliff Dr.,2A	1225 East Cliff Dr., 2A	Address: ______________________
El Paso, TX 79902	El Paso, TX 79902	City, State: ______________________
915.598.3338 [phone]	915-598-3338 [phone]	Phone #: ______________________
915.598.3339 [fax]	915-598-3339 [fax]	Fax #: ______________________

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

______________________________ ______________________

Patient's [or Legal Guardian or Authorized Party's] Signature *Date Signed*

____

Patient's [or Legal Guardian or Authorized Party's] Printed Name