Pro Active Podiatry
Foot & Ankle Specialists

Dr. Parichart Vaikayee, DPM,FACFAS

Dr. Eric Steen, DPM, FACFAS

Authorization for Release of Medical Records Information

OBTAIN FROM: *(who is releasing information?)*

Name:_____

Address:_____

_____

Phone:_____Fax:_____

RELEASE TO: *(who is receiving information?)*

PRO ACTIVE PODIATRY
3535 S Lafayette St, Suite 110
Englewood, CO 80113
Phone: 720-600-2240
Fax: 720-310-2162

SPECIFIC INFORMATION TO BE REQUESTED: For the following dates:_____

☐ All Medical Records ☐ X-Rays ☐ Lab/Path results

☐ Operative Reports ☐ Progress Notes ☐ History & Physical Exam

☐ Other:_____

THE INFORMATION ABOVE IS TO BE USED FOR:

☐ Continuity of Care ☐ At the request of the individual ☐ Legal Purposes

☐ Other:_____

I understand that once the information is disclosed, the information is subject to re-disclosure and may no longer be protected by the federal privacy regulations.
I **understand that** this authorization will expire in one year from the date signed below.
I understand that this form may be revoked at any time providing the information has not already been disclosed. I may revoke this information by notifying this office in writing.
I understand I can refuse to sign this authorization. I need not sign this form to assure medical treatment or services.
I may receive a copy of this signed authorization upon request.

Print Patient Name:_____**DOB** _____

Signature of Patient or Guardian:_____

Today's Date:_____