Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

___ I authorize Diagnostic Foot Specialists to **release medical records to:**	***OR***	___ I authorize Diagnostic Foot Specialists to **obtain medical records from:**
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, Zip Code		_____ City, State, Zip Code
_____ Phone #/Fax #		_____ Phone #/Fax #

TYPE OF RECORDS REQUESTED: (Select one or more, as applicable)

- ☐ X-ray report(s)
- ☐ Laboratory test results
- ☐ All medical records
- ☐ Other: _____

Date(s) of treatment: _____

I understand that any x-ray(s) released from Diagnostic Foot Specialists are the property of Diagnostic Foot Specialists and must be returned to them after being viewed and interpreted by the above named party.

Signature of Patient _____ Date _____

Relationship to Patient (if requester is not the patient) _____