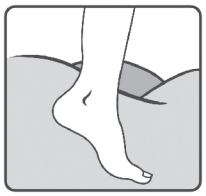

Medford Foot & Ankle Clinic, P.C.

Michael A. DeKorte, DPM, FACFAS*
Rick E. McClure, DPM, FACFAS*
Jeffery D. Zimmer, DPM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

Phone Number:_____ Social Security #:_____

I authorize information Release FROM:

_____
Name of Clinic

_____
Name of Physician

_____
Address

_____
City, State, Zip

_____
Phone

_____
Facsimile (FAX)

Please send my records TO:

_____
Name of Clinic

_____
Name of Physician

_____
Address

_____
City, State, Zip

_____
Phone

_____
Facsimile (FAX)

Purpose of Release: (Please check)
_____ Change of Physicinas _____2nd Opinion _____Other:_____

Permission to FAX Information: _____Yes _____No
I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot always be guaranteed.

Type of information to be released: _____ All items below

_____ Medication Summary _____ History & Physical _____ Path/Lab Reports

_____ Consultations _____ Progress Notes _____ X-Ray Reports

_____ Operative Reports _____ Medical Studies Other: _____

For the following dates of service; from _____ to _____

AUTHORIZATION TO RELEASE INFORMATION:

_____ _____
SIGNATURE *RELATIONSHIP TO PATIENT* *DATE*

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