Medford Foot and Ankle Clinic, P.C.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #_____

I authorize information Release FROM:

Please send my records TO:

Name of Clinic_____

Name of Physician _____

Address _____

City, State, Zip _____

Phone _____
Facsimile (FAX)

Name of Clinic _____

Name of Physician _____

Address _____

City, State, Zip_____

Phone _____
Facsimile (FAX)

Purpose of Release: (Please check)

_____Change Physicians _____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: _____