FAMILY FOOT HEALTH SPECIALISTS, P. C.

Records Release Authorization

Name _____

Address _____

_____

_____

E-mail_____

Phone_____

I hereby authorize and request Family Foot Health Specialists, P. C. to release my medical records to Doctor and/or Hospital:

_____

_____

_____

_____

Please include phone numbers, fax numbers and any email addresses, if available.

The complete medical records in Family Foot Health Specialists, P. C.'s

possession, concerning my illness and/or treatments during the period form

_____ to _____ *(please enter any/all dates)*

_____ _____

Signature Date

_____ _____

Witness Date