TRAVELING PODIATRY CARE

Authorization to Release Medical Records / Information

To: _____

_____

_____

You are authorized to release any and all medical records related to my medical condition and treatment that I may have had during the following time period listed immediately below:

From _____ to _____

To the following person(s), company or government institution:

Name: Traveling Podiatry Care
Address: PO Box 6033
City, State, Zip: Fishers, IN 46038
Phone: 317-827-2987
Fax: 317-219-0879

A photocopy of this authorization shall have the same force and effect as an original.

I have executed this document on the _____ day of _____ 20_____. This authorization is valid for 60 days from the date of execution.

Name of Patient: _____ DOB:_____

Address: _____

City, State, Zip: _____

Phone: _____ SSN: _____

Patient Signature: _____

If patient is unable to sign:

Authorized Representative Name: _____ POA: Yes No

Authorized Signature: _____

Practice Representative: _____