AUTHOURIZATION TO RELEASE HEALTHCARE INFORMATION.

PATIENT NAME DATE OF BIRTH TODAY'S DATE

I request and authorize Foundation Foot and Ankle Center to release my medical records to the following:

NAME:____

ADDRESS:____

Phone # ____. FAX # ____

FOR THE PURPOSE OF:

________ RELOCATION/MOVING

________ SECOND OPINION

________ CONTINUITY OF CARE

________ OTHER: ____

THIS REQUEST AND AUTHORIZATION APPLIES TO:

________ All healthcare information

________ Specific healthcare as indicated. ____

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE UNLESS CANCELLED IN WRITTEN BY PATIENT/LEGAL GUARDIAN

SIGNATURE OF PATIENT DATE

SIGNATURE OF LEGAL GUARDIAN RELATIONSHIP TO PATIENT DATE

____

SIGNATURE OF STAFF MEMBER RELEASING INFORMATION DATE OF INFORMATION RELEASE

THERE WILL BE A $0.10 CHARGE PER PAGE FOR MEDICAL RECORD REQUESTS