NOLA Sole PODIATRY

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Medical Records Release Form

Patient's Name _____
Date of Birth _____
Address: _____
_____
Phone Number: _____

Please release my medical records from:

Name of Provider: _____
Provider's Address: _____
_____
Office Number: _____
Fax Number: _____

Records to be released to:

Name of Provider: _____
Provider's Address: _____
_____
Office Number: _____
Fax Number: _____

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____ Date: _____
Patient's Signature