CONSENT FOR RELEASE OF INFORMATION/MEDICAL RECORDS TO DR. SCHMITT

Date: _____/_____/__________

Patient's Name: ____

Social Security #: ___________-______-___________

I hereby give my permission for ____ to release my medical records to: Southern Star Foot and Ankle located at 1441 South Midlothian Parkway, Ste 120, Midlothian Texas 76065, Fax# 972-755-4622, Tel# 972-755-4620.

Information to be released or disclosed: ____

____

For(circle one) : the period of _____/_____/__________ through _____/_____/__________ or All Medical Records

I authorize this information to be release in: O written form O verbally

The requested information will be used for: continued medical care

This consent is subject to revocation at any time in the form of written notice from me, except to the extent that action has been taken in reliance thereon, or without revocation will expire on _____/_____/__________ (not to exceed one year from today)

Signature of patient: ____ Date: _____/_____/__________

Signature of parent/guardian ____ Date: _____/_____/__________

Signature of witness ____ Date: _____/_____/__________