Bexarfoot Podiatry

PLLC

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I authorize the following physician's office/institution to release medical information on the patient listed below:

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Bexarfoot Podiatry PLLC

Address: 4334 N Loop 1604 W, STE 102

City: San Antonio State: TX Zip Code: 78249

This request and authorization applies to: Please circle one

- Entire Record
- Radiology Reports
- Office Notes
- Lab Results
- HIV/STD Record
- Mental Health
- Billing

_____ _____

Patient/Legal Gaurdian Date