Bexarfoot Podiatry

PLLC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to: Please circle one

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

This authorization shall apply to all past, present, and future periods and shall remain in effect unless revoked in writing.

_____ _____

Patient Name/Parent or Guardian if Minor Date