Dallas PODIATRY Works

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Certified in Foot Surgery, Reconstructive Rearfoot/Ankle Surgery

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CONSENT FOR RELEASE OF INFORMATION/RECORDS

DATE:

PATIENT'S NAME:

DATE OF BIRTH:

I HEREBY GIVE MY PERMISSION FOR:

Dallas Podiatry Works

(Name of agency, hospital, doctor, etc…)

***TO RELEASE OR DISCLOSE TO*:**

THE FOLLOWING INFORMATION:

Medical Records Lab/Imaging Reports X-rays Other_____
FOR THE PERIOD _____

I AUTHORIZE DR. BROOK AND DR. NORTHCUTT/DALLAS PODIATRY WORKS AND/OR HIS REPRESENTATIVE TO DISCUSS MY MEDICAL INFORMATION WITH

_____

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME IN THE FORM OF WRITTEN NOTICE FROM ME

Patient Signature*:* _____ Date_____

Parent Signature*:* _____ Date_____

Witness Signature: _____ Date_____