Dallas PODIATRY Works

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Certified in Foot Surgery, Reconstructive Rearfoot/Ankle Surgery

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Nam T. Tran, DPM

Consent for Release of Medical Records

Today's Date: _____

Patient Name: _____ DOB: _____

I hereby give my permission for ***Dallas Podiatry Works*** to release/disclose my information to:

_____ (**name of facility**)

Facility Address:

Facility Phone Number:

Facility Fax Number:

Please release the follow information:

Progress Notes **Labs** **X-rays/Imaging Reports** **Other**_____

For periods dated: _____

Patient Signature: _____ Date_____

Parent Signature: _____ Date_____

Witness Signature: _____ Date_____