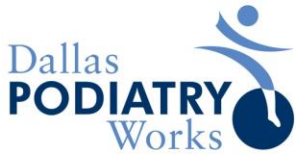


Keeping you & your loved ones active, moving & pain free.



**Joel W. Brook DPM • FACFAS**  
Diplomate American Board of Foot and Ankle Surgery,  
Certified in Foot Surgery, Reconstructive Rearfoot/Ankle Surgery

**Irene Arroyo DPM • AACFAS**

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Diplomate, American Board of Podiatric Medicine

**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 \_\_\_\_\_