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MEDICAL RECORD RELEASE FORM

Name: _____ Telephone #: _____

Address: _____ Fax#: _____

I hereby authorize the above listed entity to release medical information to McVay Foot & Ankle, P.C. :

Patient:_____ Date of Birth: _____

Address:_____ SSN: _____

Requested Information

- All Records
- Specific Records from _____ to _____
- Laboratory/ pathology records
- X-ray/ radiology records
- Pharmacy/ Prescription Records
- Billing Records.
- Others: _____

*This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

_____ _____
Signature of Patient or Legal Guardian Date Signed