



THUNDERBIRD FOOTCARE

Podiatric Medicine & Surgery

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REQUEST FOR RELEASE OF MEDICAL RECORDS

FROM:

Physician's Name: _____

Address: _____

City, State, Zip code: _____

I HEREBY REQUEST THAT MY RECORDS BE RELEASED TO:

Physician's Name: _____

Address: _____

City, State, Zip code: _____

PATIENT'S INFORMATION

Patient's Name: _____

Birth Date: _____

Social Security #: _____

Address: _____

City, State, Zip code: _____

Patient Signature: _____

Guardian Signature: _____

Power of Attorney: _____

Date Signed: _____

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