Family Foot & Ankle Clinic
Dr. Timothy L Gardner, DPM, PC

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

PATIENT NAME (Please print): _____ **DATE OF BIRTH:** _____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

The purpose/reason for this release of information is as follows:

_____

_____

SIGNATURE:

Patient's Name (Printed) _____ Patient's Date of Birth: _____

Patient Representative (Printed) _____

Signature of Patient or Patient Representative _____

Description of Patient Representative's Authority _____

Date Signed: _____

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