Westside Foot & Ankle Specialists

Podiatric Physicians and Surgeons
Jason Surratt, DPM
Thomas Melillo, DPM
Michael Gentile, DPM
Yama Dehqanzada, DPM
Todd Galle, DPM

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RECORDS RELEASE AUTHORIZATION

To:_____
(Name of Doctor releasing records, such as a primary care physician)

Patient's Name: _____
LAST FIRST MI

Patient's DOB: _____

I hereby authorize and request your office to release the following:

[ ] All Medical Records including X-Rays

[ ] Medical Records Only

[ ] X-Rays Only

[ ] Lab Test

[ ] Other:_____

To Be Faxed To: _____
Name of Medical Facility/Medical Office/Doctor/Insurance/Other

To Be Mailed To: _____
Name of Facility/ Street Number/ Suite Number/ City/ State/ Zip Code

To Be Picked Up: _____
Name of patient or relative picking up information to be hand carried to Westside Podiatry Clinic

Patient's Signature:_____ Date: _____

Please state relationship to the patient if not signed by patient: _____