

## **Authorization Form for Release of Medical Information**

Patient's Full Name:					
Patient's Date of Birth:					
Patient's Phone Number:					
Patient's Home Address:					
At the request of the individ	ual, I,	(	Patient's Name)		
do hereby authorize Shady (	irove Podiatry, l	LC to release the	following:		
The specific information	that should be	disclosed in t	he release (in	cluding dates of	service):
Information Release To (Cir	cle one):	Self	or	Facility Below	
Name of Facility:					
Address: (including city, state and zip code)					
Phone Number:					
hereby authorize disclosured may cancel this request with to the receipt of cancellation	written notifica				
THIS FORM	1 MUST BE COM	PLETED IN FULL	BEFORE SIGNING	G BELOW.	
Κ					
Patient's signature		Date		Date of Birth	1
COPY FEES AND CHARGES: F					patient

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