DOCS
DOCTORS OF CLINICAL SPECIALTIES

FOOT & ANKLE SURGEON
Dr. Jalpen Patel, DPM

RHEUMATOLOGY
Dr. Shikha Mehta, MD

Authorization to Release Medical Information

Patient information

Last Name: _____ First Name:_____

DOB: _____ SS#:_____ Phone:_____

Address: _____

City: _____ State:_____ Zip:_____

Request Record From

Name of Healthcare facility: _____

Phone: _____Fax:_____

Address: _____

City: _____ State:_____ Zip:_____

Dates of service: _____to_____

☐ Recent Labs ☐ Recent O.V. ☐ Radiology Reports ☐ Operative Reports ☐ Complete Record

I understand that this authorization extends to any and all parts of the records designated above, which may include psychiatric information, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome) and/or results from any HIV tests performed. I expressly consent to the release of information designated above unless initialized below or otherwise required by the law.

Release Records to

Name of Healthcare facility: _____

Phone: _____Fax:_____

Address: _____

City: _____ State:_____ Zip:_____

_____ _____

Signature of Patient/ Legal Representative Date

If I fail to specify an expiration date, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization was retained. I understand that I can receive a signed copy of this form upon request.

Expiration date: _____