

Date: _____

I hereby authorize:

To release the following information from my medical records:

1. Brief summaries of medical history, clinical findings and diagnosis
2. Laboratory Reports
3. X-ray Reports
4. Discharge Summaries
5. Consultations
6. Other: _____

To: _____

Signature

Date of Birth

Print Name

Social Security Number

Brett Roeder DPM

1501 North Gilbert Road #120 Gilbert AZ 85234

Phone 480 507-7560

Fax 480 507-7509

GilbertFootSurgeons.com