West Bay
Foot and Ankle

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AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

I authorize copies of my medical records to be forwarded to:

_____

Address: _____

Purpose needed:
- Continuation of Care
- Personal Use
- Insurance/Billing
- Other: _____

Dates of treatment to be released: _____

_____
Print Patient Name Date of Birth

_____
Patient/Guardian Signature Contact Phone #

Has your account ever been under another name?
If yes, please list name: _____
This authorization will expire ONE YEAR from the date signed or otherwise by my choice, in which the consent will expire on _____
If these records are being requested by a physician, please provide their name and address:
_____
_____

Please note that medical records requests normally take 10-12 business days.

IN ORDER TO COVER OUR COSTS, THERE WILL BE A CHARGE OF $1.15/PG FOR PAGES 1-20, $0.55/PG FOR PAGES 21-50 and $0.20/PG FOR PAGES 51 +, UNLESS WE ARE SENDING RECORDS TO ANOTHER PHYSICIAN'S OFFICE. X-Rays on a CD are $10. **CHARGE: $** _____