REQUEST FOR RECORDS RELEASE

Patient's Name: _________________________________ Date of Birth: ________

I hereby authorize the release of my medical records to ____________________________. I wish for them to be forwarded as soon as possible.

Patient's Signature: ____Date: ____________________
(or parent if patient is a minor)

Patient's Address: ____

City: ____ State: ____________ Zip Code: ________________

Phone:__________________________________

Patient chooses to receive by fax:_____________ or by mail:________________________

Records to be released:

□ Consultation reports □ X-ray images □ Other__________________
□ X-rays reports □ Lab reports □ All records

Please forward to: ☐ Self at address listed above

Physician's Name ____

Address ____

City ____ State _______________________ Zip Code _________

Phone: ____ Fax ____

Please note all consultation notes are sent to the primary provider you provided at your visit.

Maplewood Podiatry, LLC
2520 White Bear Ave. Suite A
Maplewood, MN 55109

Sent by:_________________________________ Date Sent:_____________________________________

Maplewood Podiatry
Maplewood ◦ Stillwater
Phone (651) 770-3891 ✦ Fax (651) 748-3117 ✦ www.maplewoodpodiatry.com ✦ info@maplewoodpodiatry.com