Quad Cities Foot & Ankle Associates, P.C

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Release of Medical Information

_____ I, the undersigned, do hereby authorize Quad Cities Foot & Ankle Associates, P.C. to release any and all medical information requested by any hospital, medical institution, clinic, physician, or other health care provider concerning my medical treatment that is in your possession and control, including but not limited to medical records, x-ray films or reports, and photographs, and to allow them to examine or duplicate same.

_____ I, the undersigned, do hereby authorize any hospital, medical institution, clinic, physician, or other health care provider to release any and all medical information concerning my medical treatment that is in their possession and control, including but not limited to medical records, x-ray films or report, and photographs, to QUAD CITIES FOOT & ANKLE ASSOCIATES, P.C.

Any photocopy of this authorization shall have the full force and effect of the original.

Patient name (printed): _____

Signature _____

DOB: _____

Date: _____