FOOT & ANKLE INST. OF NV
FORD CENTER FOR FOOT SURGERY
DOUGLAS DOXEY, DPM
CONSENT TO RELEASE MEDICAL INFORMATION

____ (Init.) We require 5 business days for completion.
____ (Init.) A completed signed authorization signed by the patient. If the patient is a minor a parent or legal guardian must sign. If other than the parent is signing a proof of Power of Attorney or Guardianship is required.
____ (Init.) According to Nevada Revised Statute 629.061 we are allowed to charge $0.60 per page for the copying of records.
____ (Init.) Records will be maintained for a period of 5 years.

Patient: ______________________________ DOB: ________________

Address: ____

Copy and send medical records to: ______________________________

Phone: ______________________ Fax: ______________________

Address: ____

____ All Office Notes Dates: ____________________
____ Lab, x-rays, or medical test data Dates: ____________________
____ All account information Dates: ____________________
____ Other Dates: ____________________

Any information you do not wish to be released? ______________________

Purpose of Release? ______________________________

This release is valid for six (6) months or until: ______________________

Signed: ______________________________ Date: ________________

Relationship: ____________________ Witness: ____________________