AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

SHEEHY
ANKLE & FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director

I, _____ , DOB: _____

Hereby authorize _____ to release my medical records, including but not limited to, operative reports, radiology reports, film copies, pathology reports, slides, and discharge summaries to: PAUL L. SHEEHY, Jr., D.P.M.

Patient Signature: _____ Date: _____