RELEASE OF INFORMATION

I, _____ hereby authorize the Broadway / Hillsboro Foot Clinic to release any and all medical records, including x-rays and other information regarding me, whether personal or otherwise to:

Doctor/Facility Name: _____

Address: _____

Phone: _____ Fax:_____

Patient:_____ DOB:_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Account #: _____