ALIGN
FOOT AND ANKLE

Dr. Zachery Barnett, FABPM ACFAS

Medical Records Release Consent

RELEASE OF INFORMATION TO:
ALIGN FOOT AND ANKLE

Dr. Zachery P. Barnett, DPM
1615 Pasadena Ave. South
Suite 280
St. Petersburg, Florida 33707

Patient Name: _____DOB: _____

Address:_____

City_____Zip_____ Phone Number _____

I hereby grant my permission to release medical information, including written or verbal communication, related to my care to Align Foot and Ankle:

I understand that this authorization may be withdrawn at any time in writing. This authorization will remain in effect for **90 days** after I sign and date the form. Recipients of my information are forbidden from re-disclosure without my specific authorization. A facsimile may be utilized with the same effectiveness as the original.

_____ _____
Patient/Guardian Signature Date

_____
Print Name of Patient/Guardian

ADMIN@ALIGNFOOTANDANKLE.COM
PHONE: 727.954.8075 | FAX: 877.834.0099
1615 PASADENA AVE. S, SUITE 280 ST. PETERSBURG, FL 33707

Align YOUR STEPS