Dr. Zachery Barnett, FABPM ACFAS

ALIGN
FOOT AND ANKLE

Medical Records Request

I hereby grant my permission for Align Foot and Ankle to release medical information relating to my care from and to the following parties:

Patient Name: _____DOB: _____

Address:_____ City_____

Zip_____ Phone Number _____

Name of Office/Doctor to receive medical records:

_____

Address: _____
Phone: _____ Fax: _____

I specify that this release includes:
1. Entire Chart – This information might include: HIV Testing and/or AIDS Treatment, Substance Abuse Treatment and/or Rehabilitation and Psychiatric Testing and/or Treatment.
OR
2. Specific Information to be released: Please specify exactly what you would like submitted (i.e., labs, x-rays, pathology reports) _____
_____
_____

I understand that this authorization may be withdrawn at any time in writing.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.

_____ _____
Signature Date

_____
Print Name

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