5819 Booth Rd
Jacksonville, FL 32207
Tel: (904) 731-1711
Fax:(904) 731-9270
www.advancedfootjax.com

MEDICAL RECORDS RELEASE AUTHORIZATION

I_____ hereby give permission for my complete
(please print name)

Medical Records to be released to: _____

From: _____

Concerning my illness and/or treatment.

Patient's Social Security # _____-_____-_____

Patient's Date of Birth _____/_____/_____

_____ Date _____/_____/_____
Signature

Driver License Info (**attach a visible copy of card with form**)

_____