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A PROFESSIONAL CORPORATION

**FRANKLIN KASE, D.P.M., F.A.C.F.A.S.**

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**OLIVER T. WANG, D.P.M., A.A.C.F.A.S.**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**I hereby request the following medical records:**

\_\_\_ **Medical Records/Progress Notes only**

\_\_\_ **Copies of X-Ray Films**

\_\_\_ **MRI/Bone Scan/Physical Therapy/Laboratory Reports - Please circle request**

**I hereby request the above records to be forwarded to:**

**Myself**

**Office/Doctor's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**A photocopy of this authorization should be considered as valid as the original.**

**Patient Name:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Witness:** \_\_\_\_\_