Foot Care Solutions, LLC
3184 West Broad Street, Suite C
Columbus, OH 43204
Phone: 614-274-7448 Fax: 614-274-4498

Authorization for Release of Medical Records

Patient Name: _____ DOB: _____

Street Address: _____
City: _____ State: _____ Zip: _____

I hereby authorize Foot Care Solutions, LLC to (circle one) **obtain records from/release records to**:

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

This authorization applies to:

___ All healthcare information
___ Only healthcare information relating to the following conditions, treatments, or specified dates: _____
_____

I release Foot Care Solutions, LLC from any liability for breach of confidentiality, misdirection of transmission, or failure to receive transmission if my records are transmitted by fax.

I understand these records may contain information from other healthcare providers as well as information that may be administrative in nature. I specifically consent to the release of any information contained in the medical record which may relate to HIV, AIDS or related conditions.

I release Foot Care Solutions, LLC from all liability which may arise from compliance with this request to release medical records.

I understand that this is an optional form and that my refusal to sign will not affect my ability to obtain treatment and that I am entitled to a photocopy of this form upon request. This release is effective for one year from the date of execution; however, it may be revoked by me at any time by providing written notice to the above named party. A facsimile or photocopy of this document will be accepted in lieu of the original.

Patient/Responsible Party Signature: _____ Date: _____
Witness to Signature: _____ Date: _____