SHELLI BREWINGTON, DPM, FACFAS

MISSION
FOOT & ANKLE

SHELLI BREWINGTON, DPM, FACAS

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Patient Name:_____ DOB:_____

SS#:_____ Phone: _____

Address:_____

I authorize:

Name:_____
Address:_____
Phone:_____ Fax:_____

to release my medical and surgical records to:

Name:_____
Address:_____
Phone:_____ Fax:_____

Date(s) of Service:_____

The information provided for the above patient will include all medical documents pertaining to the history, physical examination, and medical/ surgical treatment of the stated condition.

I DO____ DO NOT____ authorize the release of records pertaining record of substance abuse, psychological/psychiatric conditions and/ or communicable diseases, including Acquired Immunodeficiency Syndrome (AIDS) or test for infection with Human Immunodeficiency Virus (HIV), if present.

This authorization is valid for one year from the date signed. I understand that I may cancel this request with written consent and no information will be released prior to cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition to its treatment of me on whether or not I sign the authorization.

Purpose of Disclosure:

Specialist Referral Insurance Request Workers Compensation

Legal Verification Disability Records Personal
Continuing Care

Other:_____

Signature:_____ Date:_____