Earnest Foot & Ankle, PLC

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Authorization for Release of Medical Information

Please list any contacts including family, friends, both parents (if a minor) you authorize Earnest Foot and Ankle to share requested information with pertaining to your health information and/or condition. If, there is no one you want to list, note NONE. Your signature is still required, even without listed contacts.

Relationship to Patient:

Phone Number:

Contact Name:

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*Please let receptionist know if addition	nal space is needed			
Any person that calls or reque will not be given any informatibe contacted by Earnest Foot a Responsible Party.	tion pertaining to thi	s patient. Th	nose listed at	nove will not
I, <u>hereby authorize Earnest Fo</u> above. I understand that it is n any changes or updates of con	ny responsibility to c	ase informat ontact Earn	tion to the co est Foot and	ntacts listed Ankle with
Patient/ Responsible Party si	ignature .	Date		