Consent to Release Medical Information

ELITE FOOT AND ANKLE

6024 Hoover Road, Suite F, Grove City ,OH 43123 614-539-4964

I _____ Date of Birth: _____

(PLEASE PRINT NAME)

Give Elite Foot And Ankle permission to release my medical information to the following individuals.

Name: _____Date of Birth: _____

Relationship: _____ Phone #: _____

Name: _____Date of Birth: _____

Relationship: _____ Phone #: _____

Name: _____Date of Birth: _____

Relationship: _____ Phone #: _____

Signed: _____Date:_____

Witness: _____Date:_____

This form is only valid for 365 days (1 year) from the date signed.