New Braunfels Podiatry Associates
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO:_____ **DATE:**_____
_____ **PATIENT:**_____
SS#:
_____ **DATE OF BIRTH:**_____

You are hereby authorized to release the following information from my medical record to_____:

____ History & Physical ____ Progress Notes ____ X-rays
____ Operative Reports ____ Other_____

_____ _____
(Signature of patient or guardian) (New Braunfels Podiatry)