GARDEN STATE PODIATRY, LLC

CARING FOR YOUR FEET ONE STEP AT A TIME

TO: _____

PATIENT'S NAME: _____

(LAST) (FIRST)

PATIENT'S DATE OF BIRTH: _____

GARDEN STATE PODIATRY, LLC – UJJWAL DATTA, DPM / to release the following:

( ) ALL MEDICAL RECORDS INCLUDING XRAYS ( ) MEDICAL RECORDS ONLY

( ) X-RAYS ONLY ( ) LAB TEST

( ) OTHER: _____

TO BE MAILED / FAXED TO:

NAME OF MEDICAL FACILITY / MEDICAL OFFICE / DOCTOR / INSURANCE / OTHER

_____

MAILING ADDRESS – STREET NUMBER AND NAME / SUITE NUMBER

_____ CITY

STATE ZIP CODE

( ) OTHER: _____

picked up by patient or relative and to be hand carried to medical group/provider

_____ _____

PATIENT'S SIGNATURE **DATE**

(relative/guardian please state relationship)