Authorization to Release Medical Information

I, _____, give Progressive Podiatry permission to discuss the following:

____Diagnosis, Prognosis and/or treatment information

____Test Results

____Scheduling Information

____Billing Information

____Other (please specify) _____

With the following people:

_____Relationship _____

_____Relationship _____

_____Relationship _____

I also authorize Progressive Podiatry to:

___leave messages on my home answering machine

___leave messages on my work answering machine

___leave messages with co-workers

___leave messages with others residing in my household

Signature _____Date _____

Note: This form must be filled out in order to ensure the confidentiality of our patient's medical records.