

# Infinity Foot and Ankle

Dear Dr. \_\_\_\_\_:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

- \_\_\_\_\_ Complete record
- \_\_\_\_\_ Records of care from \_\_\_\_\_ to \_\_\_\_\_ only
- \_\_\_\_\_ Records of care concerning the following condition(s) \_\_\_\_\_
- \_\_\_\_\_ Other. Specify: \_\_\_\_\_
- \_\_\_\_\_ Confer with other person orally about information in my medical record

To the following person(s):

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

The reason or purposes for this release of information are:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that you will provide this information within 15 business days from receipt of request, and that you may charge a fee for preparing and furnishing this information.

The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Name \_\_\_\_\_ DOB \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient or person legally authorized to consent on patient's behalf)