

Patient Name: _____



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Lawrence M. Maurer, D.P.M.
Peter M. Vincent, D.P.M.
Surgery of the Foot & Ankle
Foot & Ankle Sports Medicine

AUTHORIZATION TO RELEASE MEDICAL RECORDS

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To:

Name of Provider _____

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Release the following information:

- Copies of all Medical Records in your possession
- X-rays or any other diagnostic imaging studies
- Laboratory Findings
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Patient/Parent Print _____

Patient/Parent Signature _____

Address: _____

Birth date: (patient) _____

Date: _____