

**Advanced Podiatry of Hampton Roads
Rex G. Diaz, DPM, FACFAS**

RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

I authorize the release of any/all information regarding my medical history, current medical condition, current medical treatment and any/all patient account information to the individual(s) listed below:

NAME: _____ RELATIONSHIP _____

NAME: _____ RELATIONSHIP _____

NAME: _____ RELATIONSHIP _____

This authorization remains in effect until I submit a written request to cancel this authorization.

Patient Signature: _____ DATE: _____

BY SIGNING BELOW YOU ACKNOWLEDGE RECEIPT OF FORM BUT DO NOT WISH TO HAVE ANY INDIVIDUAL LISTED TO RECEIVE YOUR PRIVATE HEALTH INFORMATION:

PATIENT SIGNATURE: _____ DATE: _____