Shoreline Foot and Ankle Center, PC

Darren J. Courtright, DPM, FACFAS * Sonya L. Marshall, DPM
Dennis P. Claire, DPM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, authorize the release of the following (circle all that apply) to _____.

Medical Records
X-Rays
Lab Reports

and/or

I authorize Dr. Courtright / Dr. Marshall / Dr. Claire (circle one) to discuss my medical information with _____.

***If you give permission for the physician or staff to speak with any person other than yourself regarding your medical case/condition/results, you must list this person above and sign and date the bottom of this form.**

Signed: _____

Date: _____