Marc S. Kitrosser, D.P.M., P.A
Podiatric Medicine, Surgery, and Sports Medicine

MEDICAL RECORDS RELEASE FORM

PATIENT'S NAME:
DATE:

The undersigned hereby agrees to have Dr. Marc S. Kitrosser provide a complete copy of my medical records to the following persons:

_____ _____ _____

Physician Hospital Self

In the event that copies of x-rays are requested, please be advised that x-rays are a permanent part of your patient history with this office. In lieu of the release of the x-rays, please be advised that this office will provide your physician with an electronic copy of x-rays.

Patient's Signature

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