

Patient Name: _____



**WASHINGTON
FOOT & ANKLE
SPORTS MEDICINE**

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Peter M. Vincent, D.P.M.

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*Surgery of the Foot & Ankle
Foot & Ankle Sports Medicine*

AUTHORIZATION TO RELEASE MEDICAL RECORDS

From: Washington Foot & Ankle Sports Medicine
Lawrence M. Maurer, D.P.M.
Peter M. Vincent, D.P.M.

To:

Name of Provider _____

Complete Address _____

City/State/Zip _____

Release the following information:

- Copies of all Medical Records in your possession
- X-rays or any other diagnostic imaging studies
- Laboratory Findings
- Other, please describe _____

Patient/Parent Print _____

Patient/Parent Signature _____

Address: _____

Birth date: (patient) _____

Date: _____