PARNASSUS HEIGHTS PODIATRY GROUP

A Professional Corporation

Diseases & Injuries of the Foot & Ankle

Joel R. Clark, DPM • Jamie Kim, DPM • Colin J. Traynor, DPM

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: ______________________________

Patient Name: ______________________________ **DOB:** ______________________________

I hereby authorize ______________________________ to release my medical records to the following location:

Name: ____

Address: ____

Fax: _______ - _______ - _______ Phone: _______ - _______ - _______

Medical Records to be released:

X-ray CD ($5 fee)
Operative Report
Lab Test Results
Treatment Notes
Other: ______________________

MRI Films
MRI Report
Pathology Report
ALL MEDICAL RECORDS

Signature of Patient: ____

Signature of Doctor: ____

*Depending on the request, additional copying/handling fees may apply.

St. Mary's Medical Center
1 Schrader Street, Suite 510
San Francisco, CA 94117
T 415.759.2014 • F 415.759.2015
www.phpodiatry.com