Southwest Foot Institute
1300 N. 12th Street
Suite 503
Phoenix, AZ 85006

Office Use Only:
Date Completed: ________
Completed By: ________

Phone Number: 602/340-8686 **Fax: 602/340-8061**

Medical Records/X-Ray Release Authorization

Please print for accuracy. Complete ENTIRE form to expedite processing.

Name: ______________________________ Date: ______________________

Date of Birth: ________________________ Daytime phone # ______________

Request is for: ______Medical Records __________ X-Rays

Specify records/X-Rays needed: ____________________________________

____ **Release to myself**. I am the patient, or I am the parent or legal guardian of the pt.
****Administrative Fee: $3 per page and/or $5 per X-Ray duplication MUST be prepaid to receive the requested information.**

____**Release to other physician:**

Name: ____

Address: ____

City/State/Zip: ____

Phone: __________________ Fax: _____________

____**Obtain records from:**

Name: ____

Address: ____

City/State/Zip: ____

Phone: __________________ Fax: _____________

Signed: ________________________ Relationship to Patient: ______________

Date: ________________________