Authorization to Disclose Medical Information

Patient's Name:_____ Patient's Number:_____

Address:_____

_____

Telephone: Home ( )____-_____ Cell ( ) ___-_____ Work ( )____-_____

Date of Birth: _____

SSN: _____

Authorization

I _____ authorize _____,
(Patient name) (Physician name)

to release my medical records to: **Paul A. Richter, DPM**
Family Podiatry Group of Tampa
7926 W Hillsborough Ave, Ste G
Tampa, FL 33615
Tel# 813-886-9180 Fax # 813-888-9093