The Family Foot Care Center

Consent for release of Medical Information

Patient Name: ____

SS# ____

I,______________________________ , give my permission to have any/and or all of my medical
(print name)
information, including financial, released to the following persons:

Name		Name	
Address		Address	
Phone		Phone	
Relationship		Relationship	

Name		Name	
Address		Address	
Phone		Phone	
Relationship		Relationship	

Patient Signature	
Date	
Witnessed by (FFCC Employee):	

For internal use (Do not fill after this point)

Received by	
Chart number:	
EMR	**__Y ___N**
Comments:	