Alpine Foot & Ankle Clinic
FOOT & ANKLE CARE FOR THE WHOLE FAMILY

Authorization to Release Medical Information

Patient Name:_____ Date of Birth:_____

Previous Name:_____ Social Security #:_____

I request and authorize **ALPINE FOOT AND ANKLE CLINIC – Dr. Neibauer** to release healthcare information of the patient named above to:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or date(s):_____

□ All Healthcare information

□ Other:_____

Patient Signature:_____ Date Signed:_____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS FROM DATE SIGNED.

Dr. G. Gregg Neibauer, DPM
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