ANKLE & FOOT CENTERS OF GA
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SUWANEE GA 30024
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DR. RUPAL GUPTA
DR. JALPA PATEL
DR. JILL STEPNICKA

## ***AUTHORIZATION FOR RELEASE or RECEIPT OF HEALTHCARE INFORMATION***

PATIENT NAME: _____ DATE OF BIRTH: _____

PREVIOUS NAME (IF APPLICABLE): _____

I request and authorize Atlanta Podiatry, P.C. to release healthcare information, including x-rays, of the above named patient to:

☐ Primary Care Physician/Pediatrician: _____

☐ Specialist(s) (specify): _____

☐ Family member(s) (specify): _____

☐ All my physicians

☐ I also authorize Atlanta Podiatry, P.C. to request my healthcare information from above mentioned persons or practices.

Patient Signature (or authorized representative):_____

Print Name: _____

Date: