



Jeremy A. McVay, DPM, FACFAS
8580 Scarborough Dr., Suite #120
Colorado Springs, CO 80920
Phone: (719) 266-5000 Fax: (719) 266-6596

MEDICAL RECORD RELEASE FORM

Name: _____ Telephone #: _____

Address: _____ Fax#: _____

I hereby authorize the above listed entity to release medical information to McVay Foot & Ankle, P.C. :

Patient: _____ Date of Birth: _____

Address: _____ SSN: _____

Requested Information

- All Records
- Specific Records from _____ to _____
- Laboratory/ pathology records
- X-ray/ radiology records
- Pharmacy/ Prescription Records
- Billing Records.
- Others: _____

*This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

Signature of Patient or Legal Guardian

Date Signed