Dr. H. Kurtis Biggs, DO
Dr. Brian Wallace, DO
Dr. Jamie Weaver, DPM

Medical Record Release Authorization

Date: _____

Patient Name: _____ DOB: _____ SS#: _____

I Hereby Authorize: _____

_____

_____

To release copies of the following:

_____ Medical Records _____ Medical Records & X-Rays _____ X-Rays _____ Psych Eval

_____ HIV/AIDS Treatment _____ Hepatitis C Testing _____ Alcohol/Drug Abuse Eval

To: Dr. H. Kurtis Biggs, D.O.

Dr. Brian Wallace, D.O.

Dr. Jamie Weaver, DPM

Purpose of Release: _____ Continuing Care _____ Insurance _____ Litigation _____ Personal

This Authorization expires on the following date: _____ (If no date is specified, this release expires one (1) year from today's date.)

I understand there will be a $10.00 charge for x-rays and agree to pay for the copies at the time of pick-up.

_____
Patient Signature