"Healthier Feet the Optimum Way"

Medical Release Form

PLEASE PRINT

Today's Date: _____

Patient Name: _____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email: _____

INFORMATION REQUESTED FROM / FORWARDED TO

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ FAX: (_____) _____
Email: _____

My podiatrist seeks personal health information related to my care within the **past 12 months,** which may include Progress/Physician Notes, Problem Lists, Medication Lists, Allergy Information, Test Results (e.g. labs, x-rays, etc.), and notes from any prior podiatry/foot care. We additionally seek to forward/share personal health information related to care managed by Optimum Foot Care, LLC and its associating providers.

SEND INFORMATION TO:

Dr. Yacara Tabb - Podiatrist
Optimum Foot Care, LLC
103 Smart Place, Suite #2
Slidell, LA 70458

Phone: **(985) 463-3668** Fax: **(985) 463-3660**

I, _____ (Name), hereby grant permission to you to release confidential health information about me by releasing a copy of my medical record or a summary or narrative of my protected health information to Optimum Foot Care, LLC. I further authorize the change of confidential health information between these entities. This authorization shall remain in effect until, in writing, I choose to revoke it.

_____ _____
Printed Name Date

_____ _____
Signature Date