PATHWAY
FOOT & ANKLE CENTER

Medical Records Release

Patient Name:_____ DOB:_____

Patient Phone:_____

Patient Email:_____

I, _____ am requesting medical records, labs, xrays, and procedure reports from my visits in your office to be faxed to Pathway Foot & Ankle Center for review.

Please release records to:

Pathway Foot & Ankle Center
Phone: 469-215-2366
Fax: 469-215-2377

Patient Signature:_____ Date: _____