Achilles
Foot & Ankle

PATIENT REQUEST FOR MEDICAL RECORDS OR OTHER PROTECTED HEALTH INFORMATION (PHI)TO BE RELEASED TO OUR OFFICE.

To: _____ Fax: _____
(name of facility/physician to release the information)

Patient Name: _____ Pt #: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____ Home Phone: _____

Work Phone: _____

I hereby request that a copy of my medical records or other recorded Protected Health Information (PHI) as designated below be released to Achilles Foot & Ankle Center, Inc.

□ Office Notes

□ Diagnostic Test Results

□ X-rays

□ Other _____

My requested mode of delivery of this documentation is:

□ Fax to (804) 273-1834

□ I will pick up the documentation

_____ _____
Signature of Patient or Legal Representative) Date

This information was faxed to the above facility by:

_____ _____
Achilles Foot & Ankle Staff Member Date & Time Faxed