

# Authorization for Release of Medical Records

I, \_\_\_\_\_ do hereby request and authorize medical  
(must be patient or parent/legal guardian)

records for \_\_\_\_\_ date of birth \_\_\_\_\_ to be  
(patient name) (patient date of birth)

released/transferred from the offices of \_\_\_\_\_

**(check one)**

Records for the following dates ONLY: \_\_\_\_\_ to \_\_\_\_\_

Other: \_\_\_\_\_

All records

**To be released to:**

**McKinney Foot Care  
5337 W University Drive, Ste 100  
McKinney TX 75071  
Fax: 972-542-1728**

Richard W Swails, DPM  
Bilal Master, DPM

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(patient, parent or legal guardian)

Print Name \_\_\_\_\_

 mckinney } footcare

5337 W University Drive  
Ste 100  
McKinney, TX 75071  
p 972.542.3668  
f 972.542.1728  
mckinneyfootcare.com