FOOT AND ANKLE CENTER OF NEW JERSEY

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Authorization to Release Information

Patient Name_____

PLEASE READ, SIGN, AND DATE THE FOLLOWING INFORMATION

I hereby authorize the release of information necessary to file a claim, with my insurer, which is pertinent to my case to any insurance company involved, including any insurance company or attorneys handling a worker's compensation claim or personal injury claim.

In addition, I authorize the release of all medical records or any other pertinent information to other health care providers or organizations responsible for global treatment.

A copy of this signature is as valid as the original.

X_____ _____
Signature of patient or patient's guardian *Date*

X_____ _____
Signature of Witness *Date*