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
Sunil K Jeganathan, MD, 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