

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:

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

Richard W Swails, DPM
Fellow of the
American College of
Foot and Ankle Surgeons

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