RELEASE OF MEDICAL RECORDS

Please Print

Patient Name: ____

Date: ____

DOB: ____

I, the above patient, give permission to Southern California Foot and Ankle Specialists, the office of Dr. Robert Spencer and Dr. Nitza Rodriguez, to provide any information regarding my medical records, including but not limited to, office notes, x-rays, lab results and billing information, to the following recipients:

___________________________________	______________________________
Name	Relationship
___________________________________	______________________________
Name	Relationship
___________________________________	______________________________
Name	Relationship

If there is no one you wish to receive your information, please mark a line through this page. To make any changes to your release, please submit your request in writing to our office. Please be aware this release if void 180 days after the date signed and you may be asked for your release in the future for any of the above noted information.

___________________________________	____________________________
Patient Signature	Date

Mission Hospital Regional Medical Center MOB #1
Robert J. Spencer, D.P.M., Nitza N. Rodriguez, D.P.M.
27800 Medical Center Road • Suite 110 • Mission Viejo, CA 92691 • (949) 364-WALK (9255) • (949) 364-9250 fax
www.socalfootandankle.com