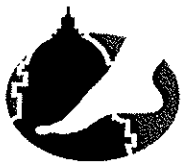

Capital Foot & Ankle
Surgeons of Austin

Consent for Release of Medical Information

Patient name:_____ Phone:_____

Address:_____

Social Security #:_____-_____-_____ Date of Birth:____/_____/_____

I the undersigned, hereby authorize:

Doctor/Faciltiy:_____

Address:_____

Phone: (____)-_____-_____ Fax: (____)-_____-_____

To disclose information relating to my medical records to:

Capital Foot & Ankle Surgeons of Austin, PLLC
2911 Medical Arts Street Bldg 17
Austin, TX 78705
Phone: 512-474-6666
Fax: 512-474-6668

Reason for disclosure:_____

Records to be released: Complete chart_____ Specific dates: From: ____/___/____ to ____/____/____
Lab reports_____
Other:_____

By signing below, I hereby consent and authorize the release of my medical records, including current and past records. I understand that this authorization includes consent for release of informatuio relating to my medical treatment, including psychological or psychiatric conditions, drug abuse, alcoholism, HIV related information (AIDS related testing), cancer testing and results or information protected to State and Federal Laws as related to a minor. I agree that a copy of thei release shall be valid as thie original. I understand I may revoke this consent at any time except that action has already been taken on it and that it will expire 1 year from the date indicated above.

Note: Federal rules prohibit you from making any further disclosure of the information

_____ _____
Patient Signature Date