MID LAKE
FOOT AND ANKLE

Breanna J. Ferguson, DPM, AACFAS
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Consent for Release of Confidential Information

Patient Name: _____ **Date of Birth:** _____

I hereby authorize and request that a copy of my medical records be released as follows:

Information to be Released From:	**Information to be Released To:**
Mid Lake Foot and Ankle	_____
Practice Name	Practice Name
870 S Duncan Drive	_____
Address	Address
Tavares, FL 32778	_____
City State Zip Code	City State Zip Code
(352) 432-8434	_____
Phone Number	Phone Number
(352) 609-8080	_____
Fax Number	Fax Number

☐ This release is to cover ALL records contained in my file.

☐ This release is to cover the following specific records: _____

_____

_____

The Purpose of this Request is for Continued Medical Care

I understand that the information contained in my medical records may include records pertaining to diagnosis, evaluation, or treatment of any emotional condition or disorder, including alcoholism and/or drug addiction. Records may also contain information regarding test results for AIDS, HIV infection, antibodies to HIV, or infection with any other probable causative agents of AIDS.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Signature Date