

David K. Lee, D.P.M. _____

A PROFESSIONAL CORPORATION



1300 N 12th St, Suite 503, Phoenix, Arizona 85006

Request for Release of Medical Records

Old Doctor's office:

Name of Practice: _____

Address: _____

City: _____ State: _____

Zip: _____

_____ is presently being treated in this office for a Podiatric problem and
Patient Name

request that you release the following information to our office:

By Email: davidklee@cox.net

By Mail:
1300 N 12th St, Suite 503
Phoenix, Arizona 85006

By Fax: (602) 258-6171

Thank You.

I HEREBY AUTHORIZE YOU TO RELEASE MY MEDICAL RECORDS TO
SOUTH WEST FOOT INSTITUTE

Printed Patient's Name

Patient's or Guardian's or Authorized Signature

Date: ____/____/____