DeLand Foot&Leg CENTER

Excellence in care as you walk through life

Authorization for Release of Medical Records to Dr. Pulapaka's Office

Patient's name: _____

Date of birth: _____

Social Security Number: _____

I hereby authorize_____

(Name of doctor/office/hospital/imaging/labs/etc)

to release the **BELOW** medical information from my personal medical records to Deland Foot and Leg Center(describe, generally, the information desired to be released, ie progress notes, labs, x-rays, etc):

_____

_____

I give my permission for this medical information to be used for the following purpose - patient evaluation.

_____ Date _____

Patient Signature

Dr. Jenneffer Pulapaka, DPM, AACFAS

Podiatric Surgeon

844 North Stone Street, Suite 208 ~ DeLand, FL 32720 ~ Phone/Fax: 386.738.3733