Graser Podiatry & Bunion Surgery Inst.

RECORDS RELEASE AUTHORIZATION FORM

ATTENTION:

____
Department

____
Doctor/ Facility

____
Fax

____/____/_____
Date

I, ______________________________________ HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS
Patient Name
AND INFORMATION REQUESTED BY AND TO:

Graser Podiatry & Bunion Surgery Institute
Dr. Robert E. Graser DPM. PA
17 Old San Antonio Rd. Ste. #201
Boerne TX. 78006
Ph: 830-253-0008 Fax: 830-253-0007
Email: DrRobertEGraser@hotmail.com

The medical records to be released are regarding my condition and/or treatment during the dates of:

_____/_____/_______ TO _____/_____/_______
Date Date

RE:

____ ____/____/______ ____________________
Patient Name (PRINT) DOB Phone #

____
Address City State Zip

____
SIGNATURE (If relative state relationship)

PT ID# ____________________
(Office use only)