ADVANCED FOOT CLINICS

Dr. Stephen S. Pirotta, D.P.M.

MEDICAL RELEASE FOR CHILD
FROM OUR OFFICE

DATE:

I, ________________________________, authorize the release of my child, ________________________________, medical records and x-rays documenting his/her care from Dr. Stephen S. Pirotta, D.P.M. to Dr_________________________.

____
Signature

____
Relationship to Patient

____
Witness