

ADVANCED FOOT CLINICS

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

**MEDICAL RELEASE FROM ANOTHER DOCTOR'S
OFFICE TO BE SENT TO OUR OFFICE**

DATE:

I _____, authorize the release of all my
medical records and x-rays documenting my care from Dr. Pirotta, D.P.M. and
send to Dr. _____.

Signature

Witness