Mendoza Podiatry

Gina Mendoza DPM PC

Medical Records/Information Request Form

I, _____ authorize Dr. _____ to release my medical records to the office of Dr. Gina Mendoza of Mendoza Podiatry for the purpose of medical treatment.

Telephone # of Releasing Doctor: _____

Fax # of Releasing Doctor: _____

Date of Birth of Patient: _____

Printed Name of Patient: _____

Signature : _____

Date Signed: _____

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