



# Newtown Foot and Ankle

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## Record Release Authorization

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I hereby authorize and request you to release to Newtown Foot & Ankle Specialists any medical records that are requested by this office.**

Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_