



Alpine Foot & Ankle Clinic
FOOT & ANKLE CARE FOR THE WHOLE FAMILY

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **ALPINE FOOT AND ANKLE CLINIC – Dr. Neibauer** to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or date(s): _____
- All Healthcare information
- Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS FROM DATE SIGNED.