Dr. Edward Lang
Surgery of the Foot and Ankle

AUTHORIZATION OF RELEASE OF RECORDS TO THIRD PARTY

I, _____, hereby authorize
(patient name)

New Orleans Podiatry Associates and its affiliated agents to release my medical records,

or the medical records of my minor child _____,
(name of minor)

or a person for whom I have power of attorney _____,
(name of person)

in their entirety to _____.
(name of third party recipient of medical records)

This includes but is not limited to physician progress notes, operative reports, radiology reports, laboratory results, and any external or internal information that has been created or collected on my behalf.

Third Party Contact:

Street: _____

City: _____ State: _____ ZIP: _____

Tel: _____ Email: _____

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of Physician Date
who has verified release of records and
power of attorney when applicable

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