



Potomac Podiatry Group, PLLC

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RECORDS RELEASE

Date: ____/____/____

I _____ hereby authorize and request you to release my medical records to _____.

These records can be released to above person (check one):

____ Via E-Email at: _____

____ Via Postal Mail: **If sent via mail there is an additional fee for shipping records.*

Address: _____

The following items and/or dates of service should be released: _____

I have been informed of Potomac Podiatry Group's records release protocol. I understand Potomac Podiatry Group, PLLC will not be responsible for any security breach of my personal information.

Patient Name: _____

Patient Address: _____

Patient Signature: _____ Date: ____/____/____

Doctor's Approval: _____ Date: ____/____/____

PPG Staff Member: _____

This Records Release expires 90 days after signed. Please allow up to 30 days to receive records.

Electronic Format Fees: \$15.00 Administration fee, plus \$0.37 per page for first 50 pages and \$0.18 per page thereafter

Paper Copy Fees: \$15.00 Administration fee, plus \$0.50 per page for first 50 pages and \$0.25 per page thereafter