PANEPINTO PODIATRY

FOOT MEDICINE & SURGERY

Rory Panepinto, DPM

Authorization for Release of Medical Records

I, ______________________ _____do hereby request and authorize medical records for
(must be patient or parent/legal guardian)

________________________ be released/transferred from Panepinto Podiatry located at
(patient name)

1801 Clearview Pkwy., Metairie, LA 70001, for the purpose of additional medical review by

medical professionals and/or my own personal use.

(Check One)

☐ Records for the following dates ONLY ________________ to ________________

☐ All Records

To be released to :
(please indicate name/address of recipient)

____

____

____

Signature _______________________________________ Date____________________
(patient or parent/legal guardian)

Print Name ____

504-264-3668 tel
504-210-8799 fax
1801 Clearview Pkwy.
Metairie, LA 70001
Nolafoot.com