Renaissance Foot & Ankle Center, PC
Alan R. Deroy, DPM, FACFAS
Aparna Duggirala, DPM, FACFAS

7223 Hanover Parkway
Suite B
Greenbelt, MD 20770
Ph: 301-441-2655
Fax: 301-441-2656

Authorization to Release Medical Records/X-Rays

Dear Dr. Deroy/Dr. Duggirala:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

_____**Complete record**

_____**Records of care from**_____ **to**_____ **only**

_____**X-Rays** (Please note that we do not make copies of x-rays. The original x-rays are the property of the doctor and must be returned within one month. If the films are needed longer, copies of the x-rays should be made at another radiology facility and the originals promptly returned to the doctor. The undersigned takes full responsibility for any unreturned or missing x-rays and a fee may be charged for each missing film.) **(# of films taken_____)**

_____**Records of care concerning the following condition(s)**_____

_____**Other. Specify:** _____

_____**Confer with other person orally about information in my medical record to the following person(s):**

_____

Name Street City State ZIP

The reasons or purposes for this release of information are: _____

_____

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

The fee is waived because the records are to be used for supporting an application for Disability or other benefits or assistance under Aid to Families with dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement, which confirms that such an application or appeal has Been field or is pending.

Name (printed):_____ **DOB:**_____

Signed:_____ **Date:** _____
(Patient or person legally authorized to consent on patient's behalf)

_____