DR. TREVOR R. WILLIAMS
FOOT & ANKLE SPECIALISTS, PLLC
1561 WEST 7000 SOUTH, SUITE 201
WEST JORDAN, UT 84084
F: 801-528-6558 P: 801-569-2696

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release health care information of the patient named above to:

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition or dates: _____

_____

☐ All health care information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any medical records regarding drug, alcohol or mental health treatment to the person(s) above.

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED