DR. TREVOR R. WILLIAMS
FOOT and ANKLE SPECIALISTS, PLLC
1561 W. 7000 S., Suite 100
West Jordan, UT 84084
Phone: (801) 569-2696
Fax: (801) 528-6558
www.healthierfeet.com

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:

TREVOR R. WILLIAMS, D.P.M.
FOOT AND ANKLE SPECIALISTS, PLLC
1561 W. 7000 S., SUITE 100
WEST JORDAN, UT 84084

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 records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.