

## GREENVILLE FOOT CARE, LLC

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### AUTHORIZATION FOR RELEASE OF INFORMATION

COPY FOR MEDICAL EVALUATION

TRANSFER

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NAME

MRN

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ADDRESS

CITY

STATE

ZIP CODE

I authorize Dr. Brian Kille, D.P.M. to release the medical records of the above named patient to:

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NAME OF DOCTOR OR HOSPITAL

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ADDRESS

CITY

STATE

ZIP CODE

I release Dr. Brian Kille, D.P.M. from all legal responsibility that may arise from this authorization.

PATIENT OR GUARDIAN'S SIGNATURE:

DATE

NAME (RELATIONSHIP TO PATIENT):

DR. BRIAN KILLE, D.P.M. IS NOT RESPONSIBLE FOR ANY MEDICAL INFORMATION WHICH IS RE-DISCLOSED BY THE  
THIRD PARTY TO WHOM INFORMATION IS FURNISHED UNDER VALID AUTHORIZATION.