Cascade Foot Center
3474 Liberty Rd S
Salem, OR 97302

PERMISSION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

From: Name: _____
(Medical Provider Holding Records)

Address: _____

City: _____ State: _____ Zip: _____

To: Name:_____

Address: _____

City: _____State: _____ Zip: _____

Phone #: _____ Fax #: _____

Email: _____

Please circle requested records: Chart Notes X-rays (will be copied onto a disc)

The following date of service: From _____ Through _____

This request will expire in 6 months from the signed date or: _____
(Specific Expiration Date)

_____ _____
Print name Relationship if signed by representative

_____ _____
Signature Date