Quad Cities Foot & Ankle Associates, P.C.

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Release of Medical Information

I, the undersigned, do hereby authorize any hospital, medical institution, clinic, physician, or other health provider to release any and all medical information they request concerning my medical treatment that is in your possession and control, including but not limited to medical records, x-ray films, and photographs, and to allow them to examine or duplicate same.

Any photocopy of this Authorization shall have the full force and the effect of this original.

Signature: _____

Date:_____

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