



Dr. H. Kurtis Biggs, DO  
Dr. Brian Wallace, DO  
Dr. Jamie Weaver, DPM

**Medical Record Release Authorization**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

I Hereby Authorize: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To release copies of the following:

- Medical Records       Medical Records & X-Rays       X-Rays       Psych Eval
- HIV/AIDS Treatment       Hepatitis C Testing       Alcohol/Drug Abuse Eval

**To: Dr. H. Kurtis Biggs, D.O.**

**Dr. Brian Wallace, D.O.**

**Dr. Jamie Weaver, DPM**

Purpose of Release:  Continuing Care     Insurance     Litigation     Personal

This Authorization expires on the following date: \_\_\_\_\_ (If no date is specified, this release expires one (1) year from today's date.)

I understand there will be a \$10.00 charge for x-rays and agree to pay for the copies at the time of pick-up.

\_\_\_\_\_  
Patient Signature