

Central Illinois Foot & Ankle Center

Permission Form

I _____ give Dr. Scott O'Connor D.P.M.
Patient's Name Doctor's Name

My permission to:

- | | YES | NO |
|--|-------|-------|
| 1. Leave medical information on answering machine, voicemail, etc. | _____ | _____ |
| 2. Leave medical information with family members listed below. | _____ | _____ |
| 3. Release medical records to the following individuals listed below | _____ | _____ |

_____/_____/_____
Date

Signature

- Please list individual by name
- Anyone not listed will not be given access to your medical records or information

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____