



Dr. Rachel O'Connor, DPM

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RECORD REQUEST

Date: _____

I hereby authorize: _____ to release the following information from my medical records to Flagstaff Foot & Ankle Specialists:

1. Brief summaries of medical history, clinical findings and diagnosis
2. Laboratory Reports
3. X-Rays
4. Discharge Summaries
5. Consultations
6. Other: _____
7. All Records

Signature

Date of Birth

Print Name