



Thomas A. LeBeau, DPM, FACCS

RELEASE OF MEDICAL INFORMATION

- 1) I GIVE MY PERMISSION FOR THOMAS LEBEAU, D.P.M. TO OBTAIN MEDICAL RECORDS FROM ANOTHER PHYSICIAN AS DEEMED NECESSARY FOR MY CARE AND TREATMENT.

- 2) I give my permission for THOMAS LEBEAU, D.P.M. and/or staff to speak with and/or release my medical records to:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient's Name (PLEASE PRINT)

Signature

Date