APPLE HILL PODIATRY ASSOCIATES, P.C.

DEE STELMACH, D.P.M., FACFAS
DAVID F. BASKWILL, D.P.M., FACFAS, FACFO
IJAZ A. ZIA, D.P.M., FACFAOM

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____, hereby request the release of all my medical

records for services provided to me by Apple Hill Podiatry Assoc., PC to be sent to:

_____

_____

_____

_____ _____

Patient Signature Date