



CHINOOK

FOOT & ANKLE CLINIC

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Todd Bolokoski D.P.M
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L. Tyler Schow D.P.M.

Patient Name _____ Date of Birth _____

Patient's Maiden Name _____ Telephone _____

Patient's Address _____

Records Requested _____

Please release my medical records FROM: _____

Please release my medical records TO: _____

Patient's Signature _____

Date _____

This authorization expires 90 days after the above signature date.