

**FOOT AND ANKLE CENTER OF NEW JERSEY**  
DR. ROBIN BOCRA, DPM  
DR. WILLIAM SLOTTER, DPM  
DR. ROBERT THIELE, DPM  
DR. NICOLE DELAURO, DPM

Authorization to Release Information

Patient Name \_\_\_\_\_

**PLEASE READ, SIGN, AND DATE THE FOLLOWING INFORMATION**

I hereby authorize the release of information necessary to file a claim, with my insurer, which is pertinent to my case to any insurance company involved, including any insurance company or attorneys handling a worker's compensation claim or personal injury claim.

In addition, I authorize the release of all medical records or any other pertinent information to other health care providers or organizations responsible for global treatment.

A copy of this signature is as valid as the original.

X \_\_\_\_\_  
*Signature of patient or patient's guardian* *Date*

X \_\_\_\_\_  
*Signature of Witness* *Date*