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DIPLOMATES, AMERICAN BOARD OF PODIATRIC SURGERY
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I authorize the release of my medical or other information necessary to process health insurance claims submitted to my carrier for services provided by **MICHAEL J. TREPAL D.P.M**. or **KEVIN T. JULES, D.P.M.**

PATIENT OR GUARDIAN SIGNATURE

I authorize payment of medical benefits to **MICHALE J. TREPAL, D.P.M. & KEVIN T. JULES, D.P.M., P.C.** for services rendered on the dates below.

DATE OF SERVICE	**PATIENT SIGNATURE**