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AUTHORIZATION OF DISCLOSURE OF HEALTH INFORMATION

Please complete this form only if you give permission for our office to release any protected health information to someone other than yourself. (Example: Spouse, Child, Friend/Relative)

I, _____, _____, hereby authorize my
Patient's Full Name Date of Birth
protected health information to be release to: _____.
Recipient's Full Name

INFORMATION TO BE RELEASED:

- Entire Medical Record
- Consult notes including examination and treatment
- Billing/Payment Information
- Appointments
- Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization – I understand that disclosure of this health information is voluntary. I will be provided with a signed copy of the form upon my request.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and /or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Professional Foot and Ankle Centers at any time.

Unless otherwise revoked, this authorization will expire on the following date, event, or circumstance:

_____.
This Authorization expires on _____. If no expiration is stated, this authorization will be deemed to expire one year from date signed.

Patient Full Name (Printed)

Patient Signature

Date