ASSOCIATED PODIATRISTS, LLP

BETTER FEET ◆ BETTER HEALTH ◆ BETTER LIFE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Previous Name: _____ SS No. _____

I request and authorize _____
to release healthcare information of the patient named above to:

Name: _____

Address: _____

Phone/Fax No.s: _____

INFORMATION REQUESTED (X): ( ) Medical Record - Entire Record

******If only a portion of the Medical record is required please specify *******

( ) Progress Notes ( ) Operative Reports ( ) Laboratory Results ( ) Nurses Notes ( ) X-Ray Reports ( ) Radiology Film *
( ) Other (Specify) _____

Identify date of service or date ranges requested including month and year: _____ To _____

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):
( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes ( ) Personal Interest ( ) Other (Specify)_____

The authorization must be signed and dated and may be revoked by notifying Associated Podiatrists LLP in writing at any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date below or sooner by my choice, in which case this consent will expire on this date or event _____. Such expiration date or event has not occurred.

REQUEST FOR RECORD COPY RELEASE WILL BE HANDLED WITHIN 3 BUSINESS DAYS OF RECEIVING REQUEST

( ) Requests for copies for personal use will incur a charge of 25¢ per page. All other forwarded at no charge.
* Free copies exclude copies of x-ray films. A separate fee of $10 each film will be assessed if these items are requested.

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature _____ **Date** _____

Patient, Parent or Legally Authorized Representative

Relationship to the Patient: _____ **Phone Number** _____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentially is protected by federal and/or state law. Federal and state regulations prohibits you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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