Foot & Ankle Centers

The Centers for Foot and Ankle Surgery, Ltd

Medical Records Release of Information Form

I hereby authorize The Centers for Foot and Ankle Surgery, Ltd dba/ **Foot and Ankle Centers** to disclose my protected health information as described below. I understand this authorization is voluntary. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand I may see and copy the information described on this form if I ask for it, and I will receive a copy of this form after I sign it. I understand I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

** **Required Doctors signature PRIOR to release of medical records**** Doctors signature_____

Patient name: _____ Date of birth: _____

SEND TO: (receiving medical record) _____

Ph#: _____ FAX TO:_____

Medical Records to be released/disclosed: (**labs, radiology reports not ordered by our office will not be provided; patient needs to request them from the provider that requested the orders**): ☐ **Complete Medical Record OR**

Please specify one or more:

- ☐ Operative Reports
- ☐ Progress Notes
- ☐ Digital X-rays
- ☐ **Film** X-rays (see practice manager/return date)____
- ☐ Laboratory Results
- ☐ Billing & Claim reports
- ☐ Other (Specify):_____

Medical Records are to be used/disclosed for the following purposes(s) only (no purpose need be stated if patient doesn't wish to state):_____

This authorization will expire on _____ (state date or event).

SPECIFIC AUTHORIZATION

I understand my health information to be released MAY INCLUDE information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, **unless I have crossed it out, and initialed it.**

Signature (patient/patient's representative):_____ Date:_____

(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_____

Relationship to patient (if applicable):_____

YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT

654 W. Veteran's Parkway; Suite D
Yorkville, IL 60560
Ph#: 630-553-9300 / Fax#: 630-553-9306

1802 N. Division; St. Suite 305
Morris, IL 60450
Ph#: 815-942-9050 / Fax#: 815-942-9051