FOOT & ANKLE CENTERS

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***Certified by the American Board of Foot and Ankle Surgery**

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FootAndAnkleCenters.com

AUTHORIZATION
TO RELEASE MEDICAL RECORDS

I hereby authorize **The Centers for Foot and Ankle Surgery, Ltd dba / Foot & Ankle Centers & Revitalize Physical Therapy** 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 that I may revoke this authorization at any time by providing written notice to Foot & Ankle Centers, but 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.

Patient's Name: _____ **Date of Birth**: _____

Telephone Number: _____ **Account Number:** _____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

Dates of Service from: _____ to _____ are authorized for release.

☐Complete Medical Record ☐ Laboratory/Pathology Results ☐Physical Therapy Notes

☐Office Visit Notes ☐Operative Reports ☐Radiology Images on CD ☐Other (specify): _____

RELEASE/SEND RECORDS TO: (Self/Physician Office/Other) _____

_____

METHOD OF DISCLOSURE: ☐Paper Copy/Pick-up ☐Fax # _____ ☐Encrypted Email: _____

PURPOSE OF DISCLOSURE: ☐ Continued Care ☐ Personal ☐Legal ☐Insurance/Billing ☐Other

********You will be notified regarding charges associated with processing this request.********

Unless revoked by me sooner or restricted to a shorter time period by applicable law, this authorization shall be effective until _____ (MM/DD/YYYY) after the date of my signing below.

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 the release of all such information unless I have crossed it out and initialed it.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

_____

If not Patient, the Relationship of Legally Authorized Representative to Patient

OFFICE USE ONLY:
Required Doctors signature PRIOR to release of Medical Records Doctors signature _____
***Charges: $**_____