Authorization for Release of Medical Information

Patient name: _________________________ DOB: ___________________

I __________________, hereby authorize Central Texas Foot Specialist, P.A. to release/request my protected health information (PHI) as described below:

SEND RECORDS TO:

Name: ____

Address: ____

Phone: ______________________________ Fax: _________________________________

REQUESTING RECORDS FROM:

Name: ____

Address: ____

Phone: ______________________________ Fax: _________________________________

General Information Requested:

Medical Information Requested:

( ) Complete medical records

( ) Lab Reports/Diagnostic Reports

( ) Imaging Reports

( ) Progress notes with medication list

( ) Immunizations

( ) Other: ____________________

Reason for Release:

( ) To update primary care doctor

( ) I have been referred to another doctor

( ) Second opinion/ I am changing doctors

( ) Change of insurance

( ) I am moving (new address)

( ) Dissatisfaction with care

( ) Other: _________________________

I understand that the information in my health record may include information relating to substance abuse, mental health/depression and or HIV related information.

____Yes, I consent to the release of this information. ____ No, I do not consent to the release of this information

This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information. Restrictions: The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

____________________________________ ______________

Signature of patient/authorized representative Date

____________________________________ ______________

Signature of Witness Date