

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Phone: H) _____ Phone: C) _____

Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes Advanced Regional Center for Ankle and Foot Care to make record disclosure:

Dates and Type of information to disclose: All Records Other _____
 Clinical Notes Lab Reports Radiology Reports Pathology Reports

RESTRICTIONS: Only medical record originated through Advanced Regional Center for Ankle and Foot Care will be electronically sent/faxed/copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

Fax: _____ Phone: _____

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Compliance Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

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

If I fail to specify an expiration date, event or condition, this authorization will expire one (1) year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided by the HIPAA rule CFR 164.424. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact Advanced Regional Center for Ankle and Foot Care's Compliance Officer.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

_____ Date

_____ Printed name of Authorized Representative

_____ Relationship/Capacity to patient

_____ Address and telephone number of authorized representative