Foot & Ankle Specialists of the Mid-Atlantic

Keeping you on track...For Life!

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Foot & Ankle Specialist of the Mid-Atlantic to disclose the following information from the Health records of:

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____ SSN: _____

Covering the dates of service: From _____ Through _____

(Date) (Date)

I authorize Foot & Ankle Specialist of the Mid-Atlantic to release the following medical reports. I understand the the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services , and treatment for alcohol and drug abuse.

Please check desired information to be sent :

☐ Complete Record	⇖ X-Ray Reports	⇖ History & Physical
⇖ Lab Reports	⇖ Pathology Reports	⇖ Physical Therapy Reports
⇖ MRI Results	⇖ Vascular Reports	⇖ Abstract of Record (as listed above)

This information is to be disclosed to: _____

_____

_____

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For the purpose of: _____

_____

_____

I understand this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in one (1) year. 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 ensure treatment. I understand that i may inspect or have copied the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

Foot & Ankle Specialist of the Mid-Atlantic is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____ or _____

(Date) (Patient Signature) (Person Authorized to Consent)

_____ _____ _____

(Date) (Witness Signature) (Relationship to Patient)