ADVANCED FOOT & ANKLE CENTER

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

Name: _____
Address: _____
City State Zip: _____

Phone: _____

DOB: _____

I authorize Advanced Foot & Ankle Center, SC to release health information from the medical record of the above patient.

The information will be released to:
Facility/Provider/Person: _____

Fax: _____ Phone: _____ Email: _____

Dates of service for records request: _____

HIV, mental health, and drug/alcohol information contained in the records indicated above will be released through this authorization unless otherwise indicated. If you do not want this information released please initial here. _____

I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the facility where the authorization was originally created. I realize that if I cancel this authorization, it will not affect uses and/or disclosures of my information that have already occurred based upon my authorization. Photocopy/fax copy is as valid as the original.
REDISCLOSURE: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Patient or Representative Signature: _____ Date:_____

Printed name of Representative: _____ Phone#: _____

Advanced Foot & Ankle Center, SC reserves the right to assess a charge for labor and supplies for making photocopies. First 25 pages $1.40 per page. Rates after 25 pages upon request.