



AUTHORIZATION for the Release of Health Information

Patient Name Phone Number
Address Street City, State, Zip
Date of Birth: MM DD YY

- I hereby authorize Family Footcare to RELEASE my medical information to Health Provider or Entity
I hereby authorize Family Footcare to RECEIVE my medical information from Health Provider or Entity

Name Attention of
Street Address City, State, Zip
Telephone # Fax # (required for Health Provider)

Information to Release (check all that apply)

- Medical Records from to
Entire Medical Record, including patient history, office notes, test results, radiology reports and consults
Billing records
Other:
Include by Initialing: Alcohol / Drug Treatment HIV Related Info and Test Results Mental Health Information

Medical Records Released by Family Footcare Group / Copying Fee: \$0.75 per page

- X-Ray (dates) X-Ray CD Cost \$10.00 / disk

Authorization to Discuss Health Information

By initialing here, I authorize to discuss my health information with:
Initials Name of Individual health care provider
(Name) (Relationship)

Reason for Requested Use or Disclosure

- Personal Use Legal Second Opinion Change in Health Care Provider
Other (specify)

This authorization expires in six (6) months from the date signed or earlier

TO BE READ AND SIGNED BY PATIENT:

- I understand the following:
a. I may revoke this authorization at any time by providing written notice to the practice
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so
e. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use
g. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate box above.
h. If I am authorizing the release of HIV related, alcohol or drug treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of disclosure of HIV related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

Signature of Patient or Legal Representative Date