Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

_____ **Phone:**_____**Fax:**_____

(Name of the entity)

May release the following information:

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ Marketing*
☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list):

☐ Other as listed: _____

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name: CAROLINA FOOT AND ANKLE ASSOCIATES_____

Address: 1501 TATE BLVD SE STE 203_____

City, State, Zip: HICKORY, NC 28602_____ Phone: 828-304-0400 Fax 828-304-0142

☐ For **fax communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____ Date: _ _____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)