Authorization to Release Medical Records to Desert Foot and Ankle, P.C (DFA)

I hereby authorize _____, located at_____,
Healthcare Provider Name *Address*
to release my Medical Records and/or [type of record] records to Desert Foot and Ankle, P.C.

Patient's Name: _____Phone number: _____

Address: _____
Street City State Zip Code

Date of birth: _____ Date of request: _____

Medical Records are to be sent to: _____
(*Provider Name and Address)*
Fax Number records to be faxed to: _____

Please check and complete all that apply.

- ☐ Medical Records for Date(s) of: _____
- ☐ Imaging and Area for Date(s) of: _____
- ☐ Other, please be specific: _____

Health Information to being disclosed for the following purpose: (check all that apply)

- ☐ *Change in Insurance or Healthcare Provider*
- ☐ *Continuation of Care*

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may be revoke this authorization at any time by giving oral or written notice to DFA. A photocopy of this authorization shall constitute a valid authorization. I realize once my medical records have been released to DFA, my revocation cannot be effective to the extent which the healthcare provider has taken the action and with the reliance of this Authorization.

I understand that the health information I am authorizing may disclose additional information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

I understand that DFA may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I have read this Authorization and I acknowledge being familiar and fully understand it's terms and conditions.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name of Personal Representative and Relationship Telephone Number

Reference Number 11.03

Revised Date	*Author*