Medical Records Release

Patient's Name: _____ Date of Birth: _____

Street Address: _____ Social Security No: _____

City, State & Ziip: _____ Home Telephone: _____

I hereby authorize the release of my medical records as marked below:

☐ **TO** ☐ **FROM**

1Foot 2Foot Centre for Foot and Ankle Care, PC
171 North Main Street
Suffolk, Virginia 23434
Phone: (757) 934-0768 / Fax: (757) 925-1901

☐ **TO** ☐ **FROM**

Facility Name: _____

Address: _____

City, State & Zip: _____

Phone: _____

- ☐ All Office Notes / Correspondence, except _____
- ☐ All Medical Reports/Labs/X-ray, except _____
- ☐ All Medical Records, except _____
- ☐ Limit release to the following information:

_____

_____

Purpose of Disclosure:

- ☐ Medical Treatment / Continuing Care
- ☐ Other (please list)

_____

_____

I _____, authorize disclosure of protected health information on the above named patient. This authorization is valid for 6 months from the date signed. I understand I can revoke this authorization with written notification,but that it will not affect any information previously released prior to the notice of cancellation. I understand the information disclosed may be subject to re-disclosure by the person, persons, or facility receiving and would no longer be protected by federal regulations. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____