

Queen City Foot and Ankle Specialists P.C.

Medical Records Release / Authorization to Disclose Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All my health information maintained by the above-named practice
- My health information relating to the following treatment or condition: _____
- My health information for the date(s): _____
- Other: _____

Name of Facility/Doctor **RELEASING RECORDS:** _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Fax: _____

Name of Facility/Doctor **RECEIVING RECORDS:** _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Fax: _____

Reason(s) for this authorization (check all that apply):

- at my request
- other (specify) _____

This authorization ends only upon written request of the patient

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.
- or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Queen City Foot and Ankle Specialists based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office.
- or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)