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Authorization for Release of Protected Health Information

Patient name **Date of Birth**

Address **Telephone Number**

I hereby authorize (Name of facility/provider **releasing** information) **to disclose the above-named individual's health information:**

Name (facility releasing information) Address City State Zip

Telephone Number

Date(s) of Service Requested (if known) or Provider: ________________________________

Description of Information to be released: (check all that apply)

__Progress Notes
__Consultations
__Most recent history and physical
__Immunization record
__Other _________________________
__Laboratory reports
__Radiology/Imaging reports
__Radiology films
__Two-way verbal exchange of communication
__Entire medical record

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the information)

Name (facility receiving information) Address City State Zip

Telephone Number

Description of the purpose of the use and/or disclosure: (check one)

__Continuing Care
__Consultation
__Legal purposes
__Second Opinion
__Emergency/acute care
__Personal use
__Social Security/Disability (provide copy of SSA letter)
__Insurance
__Other: Please describe: ___________________________
__Marketing-If this request is for marketing purposes, AFAS may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's protected health information.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. Austin Foot and Ankle Specialists may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until ________________________ (date or event).

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department of Austin Foot and Ankle Specialists. If I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

____ ____

Signature of Patient or Patient's Representative **Date**

____

Printed name of Patient or Patient's Representative

____ ____

Relationship to Patient or **Legal Authority (attach supporting documentation)**