Patient Authorization for Disclosure of Health Information:

Patient Name: _____ Date of Birth: ____/____/____

Street: _____ City: _____

State: _____ Zip: _____ Phone: _____

E-mail Address: _____

I request that my protected health information (PHI) from Central Massachusetts Podiatry be disclosed to:

Recipient Name: _____

Street: _____ City: _____

State: _____ Zip: _____ Phone: _____

E-mail Address: _____

Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

□ All Medical Records

□ Medical Records between the dates of _____ to _____
Starting Date Ending Date

□ All Radiology (Xray) Imaging Studies

□ Radiology (Xray) Imaging Studies between the dates of _____ to _____
Starting Date Ending Date

□ Itemized Billing Records

□ Other (specify):_____

Term: I understand that this authorization will remain in effect:

□ From the date of this authorization until the _____ day of _____, 20____

□ Until the provider fulfills this request

□ Until the following event occurs: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records □ Yes □ No Dates: _____

HIV Testing and Results □ Yes □ No Dates: _____

Mental Health □ Yes □ No Dates: _____

Psychotherapy Records □ Yes □ No Dates: _____

Purpose for requesting information:
□ Legal □ Insurance □ Personal □ Continuation of Care □ Other: _____

Disclosure Format (Paper is default if not marked.):
□ US Mail – paper format
□ Fax (healthcare provider only)
□ E-mail (secure format)
Other (please specify): _____

By signing this authorization form, I understand that:
• Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented Central Massachusetts Podiatry. Revocation will not apply to information that has already been disclosed in response to this authorization.
• If I fail to specify an expiration date/event/condition, this authorization will expire (30 days) from the date signed.
• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
• Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Printed Name of Authorized Representative: _____

Relationship of authorizing person to patient:
□ Parent or Legal Guardian
□ Power of Attorney
□ Beneficiary or personal representative of a deceased individual