Rhode Island Foot Care, Inc.

Authorization to Release Patient Health Information

Please provide complete and accurate information when submitting this form. Rhode Island Foot Care, Inc. will only process valid and complete authorization forms.

Patient Name: _____ **Date of Birth:** ____/____/____
Last **First** **Middle Initial**

Former Name (if any): _____ **Daytime Phone:** _____

I, _____ , authorize Rhode Island Foot Care, Inc to release information as stated below from the patient health information record. This authorization is not valid to release future health care records more than 90 days from the date signed (except to a payor or as otherwise permitted under law).

Records to be released from:	**Records to be released to:**
Rhode Island Foot Care, Inc.	**Organization/Person Name:** _____
Street Address: _____	**Street Address:** _____
City, State, Zip: _____	**City, State, Zip:** _____
Telephone: _____	**Telephone:** _____

Purpose or Need for this Information:

____Continuing Care ____Copies for Own Use ____Other

TYPE OF RECORDS REQUESTED: (Charges for copies of records may be associated with your request)

☐ Progress Notes
☐ Operative Reports
☐ Radiology
☐ Other_____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Rhode Island Foot Care, Inc. has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. My written revocation must be submitted to Rhode Island Foot Care, Inc. at 649 East Avenue, Pawtucket, RI 02860.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization.

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Signature of Witness Date