Medford Foot & Ankle Clinic, P.C.

Michael A. DeKorte, DPM, FACFAS*
Rick E. McClure, DPM, FACFAS*
Jeffery D. Zimmer, DPM

Authorization to Disclose

Name of Patient; _____

I understand that if the person (s) or entity (ies) that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described below is no longer protected by those regulations.

This authorization may be revoked at any time, and must be in writing, signed by me or on my behalf, and delivered to the address at the bottom of this form. This shall remain in effect from the date of signing until rescinded by patient or on my behalf.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION & BILLING INFORMATION REGARDING PATIENT BELOW

This authorization must be written, dated and signed by patient or by a person authorized by law to give the authorization.

I authorize Medford Foot and Ankle Clinic Staff to release specific health information regarding my care and treatment; and to discuss billing and accounting inquiries on my behalf. To the following recipient (s):

Name: Relationship:

_____

_____

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Rev. 5/16

Medford Office: 713 Golf View Dr. • Medford, Oregon 97504-9643 • Phone 541-770-1225 • Fax 541-770-1245
www.medfordfoot.com
** Fellow American College of Foot and Ankle Surgeons*