Family Footcare Group LLP
427 Broadway Suite 2 Monticello, NY 12701
Tel (845) 692-3668 Fax (845) 794-0228

AUTHORIZATION for the Release of Health Information

Patient Name _____ Phone Number _____

Address
Street _____ City, State, Zip _____

Email _____ Date of Birth: _____
MM DD YY

☐ **I hereby authorize Family Footcare to RELEASE my medical information to Health Provider or Entity**

☐ **I hereby authorize Family Footcare to RECEIVE my medical information from Health Provider or Entity**

Name _____ Attention of _____

Street Address _____ City, State, Zip _____

Telephone # _____ Fax # (required for Health Provider) _____

Information to Release (check all that apply)

☐ Medical Records from _____ to _____

☐ Entire Medical Record, including patient history, office notes, test results, radiology reports and consults

☐ Billing records _____

☐ Other: _____

Include by Initialing: _____ Alcohol / Drug Treatment _____ HIV Related Info and Test Results _____ Mental Health Information

Medical Records Released by Family Footcare Group / Copying Fee: $0.75 per page

☐ X-Ray (dates) _____ **X-Ray CD Cost $10.00 / disk**

Authorization to Discuss Health Information

☐ By initialing here _____ (Initials), I authorize _____ (Name of Individual health care provider) to discuss my health information with:

_____ (Name) _____ (Relationship)

Reason for Requested Use or Disclosure

☐ Personal Use ☐ Legal ☐ Second Opinion ☐ Change in Health Care Provider

☐ Other (specify) _____

This authorization expires in six (6) months from the date signed or earlier _____

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure from any individual to do so
e. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use
g. This authorization my include disclosure of information relating to ALCOHOL and DRUG ABUSE and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate box above.
h. If I am authorizing the release of HIV related, alcohol or drug treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization. If I experience discrimination because of disclosure of HIV related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

_____ _____
Signature of Patient or Legal Representative Date