FOOT AND ANKLE CENTER OF ILLINOIS
AUTHORIZATION TO RELEASE INFORMATION

I authorize the use and/or disclosure of my protected health information as described below. I understand this authorization is voluntary and made to confirm my direction. I understand that if the persons or organizations I authorize to receive and/or use the protected health information, described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose my protected health information and it may no longer be protected by federal health information privacy laws.

Patient Name: _____ DOB: _____

Address: _____

Social Security Number: _____

Protected health information to be used or disclosed:

___Office Notes ___ Operative Report ___ Lab Results ___ X-Ray/Films

___ EMG Report ___ MRI Report ___ Bone Density Report

___ Complete Medical Record

___ Psychotherapy Notes (if this request is for psychotherapy notes you must fill out new request for all other information you wish released.)

I, the undersigned authorize and request _____ to release my protected health information to:

Dr.:_____

At: The Foot & Ankle Center Of Illinois
2921 Montvale Drive
Springfield, IL 62704

Fax Number: (217) 785-2715

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization, by submitting a notice to the facility Privacy Officer at 2921 Montvale Drive, Springfield, IL 62704. Unless revoked, this authorization will expire one year from the date of the signature, unless otherwise specified.

Signature: _____ Date: _____
(Patient, parent if minor child, or legal guardian)

Relationship to Patient: _____

OFFICE USE ONLY

Identity of requester verified via:

___ Photo ID ___ Other, specify _____

Verified by: _____