FALLBROOK PODIATRY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: _____ **Address:** _____

RELEASING PROVIDER / FACILITY

Name: _____

Address: _____

Phone: _____ **Fax:** _____

RECEIVING PROVIDER / FACILITY

Name: _____

Address: _____

Phone: _____ **Fax:** _____

RECORDS REQUESTED

Check all that apply:

- ☐ Complete Medical Record
- ☐ Office Visit Notes
- ☐ Procedure Notes / Operative Reports
- ☐ Imaging Reports (X-ray, MRI, CT, Ultrasound)
- ☐ Imaging CD (DICOM format)
- ☐ Laboratory / Pathology Reports
- ☐ Billing Records
- ☐ Insurance Authorizations
- ☐ Orthotics Records
- ☐ Clinical Photographs
- ☐ Other: _____

Date(s) of Service: From: _____ To: _____

PURPOSE OF DISCLOSURE

- ☐ Continuity of Care
- ☐ Insurance
- ☐ Legal
- ☐ Personal Use
- ☐ Other: _____

SENSITIVE INFORMATION

Initial next to each category you authorize for release:

- ☐ HIV / AIDS information
- ☐ Mental health records
- ☐ Drug & alcohol treatment records
- ☐ Genetic testing information

IMPORTANT INFORMATION

I understand that this authorization is voluntary and may be revoked at any time in writing, except to the extent that action has already been taken.

This authorization expires one (1) year from the date signed unless otherwise specified below.

Records disclosed may be subject to re-disclosure and may no longer be protected by federal or state law.

Copying fees may apply in accordance with California Health & Safety Code §123110.

Expiration Date (if different from 1 year):

PATIENT SIGNATURE

Patient Signature: **Date:**

Printed Name:

IF SIGNED BY PERSONAL REPRESENTATIVE

Name: **Relationship:**

Signature: **Date:**

FOR OFFICE USE ONLY

Date Received: Processed By:

Date Sent: Method: ☐ Fax ☐ Mail ☐ Secure Email ☐ In Person

Notes: