AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: ____
Last First Middle

Maiden Name: ______________________ Patient's SSN: ____________________
Last

Patient's Date of Birth: __________________ Telephone Number: ________________

I hereby Authorize and Request:
Brooks Foot & Ankle Associates
Name (Releaser)
2201 E Nine Mile Road
Address

Pensacola, FL 32514
City, State, Zip

To Release To:
____
Name (Releasee)
____
Address

____
City, State, Zip

A copy of the medical record ("Protected Health Information") of the above named patient pertaining to: (Check appropriate box and list the date)

☐ Office Notes ☐ Lab ☐ Pathology ☐ X-Ray

☐ Abstract (H&P, discharge summary, consult, OP report) ☐ Other ______________________

_____ I do _____ I do not authorize the release if information, including, if applicable, specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.
Releaser, its agents and employees, are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information.

This authorization will expire one (1) year from the date of my signature.

I understand that I have the right to revoke this Authorization, if the authorization is in writing except if (i) **Brooks Foot & Ankle Associates** has taken action in reliance upon this Authorization, or (ii) if this

Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

I understand that I may revoke this Authorization by providing a written revocation to:

Brooks Foot & Ankle Associates
2201 E Nine Mile Rd.
Pensacola, FL 32514.

I understand that my Protected Health Information that is used or disclosed under this authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by law.

____

Signature of Patient Date

____

Authorized Representative if Patient is unable to sign Date
With description of Authority to Sign for Patient

____

Witness Date