AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ Who resides at _____ in the

city of _____ in the state of _____ hereby authorize:

RECORD HOLDER

Name: WACO FOOT & ANKLE, P.A.

Address: 201 COLONNADE PARKWAY, SUITE 100

City: WOODWAY State: TEXAS Zip: 76712

to disclose the following specific medical information by: ☐ Mail ☐ Fax ☐ E-mail ☐ Verbal to:

INTENDED RECIPIENT

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Fax No.: _____

from the Health Records of:

PATIENT'S NAME

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

_____ Statements/Receipts of Charges or Payments

_____ Records of Visits (All Visits)

_____ Record of Visits for Specific Date or Range of Dates
*Specific dates include or are limited to: _____

_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)

_____ Progress Notes

_____ Photographs, videotapes, digital or other images

_____ Discharge Summary

_____ History and Physical Examination

_____ Insurance Information

_____ **ALL THE ABOVE**

The following items require specific authorization in order to be disclosed:

_____ Mental Health and/or Alcohol and Drug Abuse Treatment

_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information

_____ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any & all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Waco Foot and Ankle, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability form disclosure of the above authorized information to the extent indicated herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this Authorization my be subject to re-disclosure by the recipient and is no longer protected.

_____ Patient's Name Printed

_____ Date

_____ Patient's Social Security Number (for identification purposes)

_____ Patient's or Personal Representative's Signature (Guardian If A Minor)

_____ Expiration Date If Other Than 1 Year

_____ Patient's Personal Representative's Name Printed

_____ Date

_____ Witness Name Printed

_____ Patient's Personal Representative's Authority To Act

_____ Witness' Signature

CLICK TO SEND COMPLETED FORM