PROFESSIONAL Foot & Ankle Centers DAVISON • LAPEER

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ProfessionalFoot.com

AUTHORIZATION OF DISCLOSURE OF HEALTH INFORMATION

I, _____, _____, hereby authorize my
Patient's Full Name Date of Birth
Protected health information to be released to/from:

Professional Foot and Ankle Centers

605 S. State Rd. Davison, Michigan 48423
Phone: 810-653-9060 Fax: 810-658-2248

1390 N. Main St. Lapeer, Michigan 48446
Phone: 810-664-1250 Fax: 810-664-0315

RELEASE PROTECTED HEALTH INFORMATION TO/FROM:

Health Care Provider/Health Plan Representative
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Family/Friend
Name: _____
Address: _____
_____
Phone: _____

INFORMATION TO BE RELEASED:

- ☐ Entire Medical Record
- ☐ Medical History, Examination, Reports
- ☐ Surgical Reports
- ☐ Treatments or Tests
- ☐ Hospital Records Including Reports
- ☐ Billing/Payment Information
- ☐ Laboratory Reports
- ☐ Prescriptions
- ☐ Allergy Reports
- ☐ X-Ray Reports
- ☐ Consultations
- ☐ Other (Specify): _____

PURPOSE FOR NEED OF DISCLOSURE:

- ☐ Further Medical care
- ☐ Insurance Eligibility/Benefits
- ☐ Legal Investigation or Action
- ☐ Changing Physicians
- ☐ Other (specify) _____

DON'T FORGET TO COMPLETE THE OTHER SIDE

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization – I understand that disclosure of this health information is voluntary. I will be provided with a signed copy of the form upon my request.
Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and /or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to Withdraw This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Professional Foot and Ankle Centers at any time.

Unless otherwise revoked, this authorization will expire on the following date, event, or circumstance:
_____

This Authorization expires on _____. If no expiration is stated, this authorization will be deemed to expire one year from date signed.

_____
Patient Full Name (Printed)

_____ _____
Patient Signature Date