Greenville
FOOT & ANKLE CENTER

I, _____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person(s) and/or organization(s) to DISCLOSE my protected health information (as specified below):

Name(s)_____

Organization(s)_____

Address_____

I authorize the following person(s) and/or organization(s) to RECEIVE my protected health information, as disclosed by the person(s) and/or organization(s) above.

Name(s)_____

Organization(s)_____

Address_____

Specific description of the protected health information that I authorize for disclosure:

Specific description of the purpose of each use or disclosure (or write "At the request of the Individual" in this space):

I understand that I may revoke this authorization in writing at any time (by sending a signed and dated written statement to (name of person or organization and address) saying that I am revoking my authorization to disclose health records,) except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization. (NOTE: If the organization is a covered entity under HIPPA, add: I further understand that my eligibility for health benefits, my enrollment in a health plan, and my treatment will not be affected whether or not I sign this authorization.)

This authorization expires on _____

I have had the opportunity to read and consider the contents of this authorization.

_____ _____

Signed Date

Name_____DOB:_____

Address_____

Telephone_____

Relationship or Authority of Personal Representative (if applicable) _____