MID-STATE PODIATRY

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Medical Records Information Release Authorization

This form authorizes Mid-State Podiatry Group's doctors and/or staff to release/obtain information as described below.

Patient Name: ________________________________ **Date of Birth:** _______ / _______ / _______

SSN: ___________ - ________ - _____________ **Chart #:** ______________________________

Information to be released: (check those that apply)

____ **Office Notes** ____ **Laboratory Results** ____ **Operative Notes**

____ **X-Rays:** Report/Original/Duplicates ____ **All Medical Records** ____ **Billing/Account Information**

____ **Other:** ____

Information released ___from ___ to:

Mid-State Podiatry Group

Address:

1034 North Highland Avenue, Suite B

Murfreesboro, TN 37130

Phone: 615-893-4800

Fax: 615-890-0061

Information released ___ to ___ from:

Name/Organization:

____

Address:

____

____

____

Phone: ______________**Fax:** ________________

I prefer my records sent via:
____ **mail**
____ **fax**
____ **other:** _____________________

I hereby authorize the above listed entity to disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that this authorization will expire on ____ / ____ / _____ (DD/MM/YYYY). If no date is given, this authorization will expire thirty (30) days from the date of signature.

I understand that I revoke this authorization at any time by notifying ______________________ in writing, but if I do, it won't have any affect on any actions taken before receipt of my revocation.

______________________ will not condition my treatment on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my doctor from a third party.

____ ________________ __________________________

Signature of Patient/Representative **Date** **Relationship to Patient**

Adapted from APMA HIPAA Privacy Manual, page 12