THE ORTHOPAEDIC CENTER FOOT AND ANKLE RECONSTRUCTION

AUTHORIZATION TO **OBTAIN** PROTECTED HEALTH INFORMATION

**** Please Note:** all of the following information must be completed in order to process this request.

_____	_____
Print Patient's Full Name	Birth Date (Mo/Day/Yr)
_____	_____
Street Address	Social Security Number
_____	_____
City, State, Zip Code	Phone Include Area Code

I, _____, authorize the facility named below,

_____

_____

to release my medical records as marked below, dates of ALL, to:

The Orthopaedic Center for Foot and Ankle Reconstruction
100 Kingsley Lane, Suite 300
Norfolk, VA 23505
Phone: (757) 889-6580 / Fax: (757) 889-6583

____ All clinical notes, except _____ ____ All medical reports, except_____

_____ _____

____ All clinical notes, except _____ ____ All medical reports, except_____

_____

Purpose of Disclosure: _____ medical treatment / continuing care

_____ other (please list) _____

_____

I, _____, authorize disclosure of protected health information on the above named patient. This authorization is valid for 6 months from the date signed. I understand I can revoke this authorization with written notification, but that it will not affect any information previously released prior to the notice of cancellation. I understand the information disclosed may be subject to re-disclosure by the person, persons or facility receiving and would no longer be protected by federal regulations. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

Signed:_____ _____ _____

Patient or Responsible Party Date Witness