Podiatry Institute of the South, PLLC

Phone 901-390-2930 Fax 901-390-2940

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ to release or disclose to the below-named recipient all of my medical records including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease or HIV/AIDS infection (unless otherwise indicated below):

I hereby authorize the release of medical records to: PODIATRY INSTITUTE OF THE SOUTH

The authorization will expire on: _____

Date or event may not exceed one year

Purpose of release (i.e. evaluate for surgery, evaluate condition, second opinion, attorney, etc.)

_____

This Authorization applies to (check all applicable):

_____ **All medical records**

_____ **Health care information relating to the following treatment, condition, or dates of treatment:**

_____

_____

_____ **Specific records to be released (e.g. Labs, imaging reports, other):**

_____

INITIAL THE BOX FOR INFORMATION YOU DO NOT WANT TO BE RELEASED:

Drug/alcohol abuse ☐ Psychological/psychiatric treatment☐HIV/AIDS/STD☐ Sickle Cell ☐

I am aware that I have the right to inspect and receive a copy of the information I have authorized to be used and/or disclosed by this Authorization. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I am aware that I may revoke this Authorization at any time in writing; however, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) as authorized by law. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize the transfer of my health information in the manner described above.

_____ _____

Signature of Patient or Authorized Representative **Date Signed**

_____

Relationship to Patient (if signed by Authorized Representative)