ORTHOPEDIC
FOOT & ANKLE CENTER

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person or organization authorized to receive the information is not a health plan or health provider; the released information may no longer be protected by federal regulations.

Name: _____ Date of Birth: _____ Phone Number:_____

Organization providing the information: Orthopedic Foot & Ankle Center
350 W. Wilson Bridge Road, Suite 200
Worthington, OH 43085
p. 614.895.8747 **f**. 614.895.8810

Person/organizations receiving the information: Name:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Fax:_____

Specific description of information (including date(s) of service): _____

_____

_____

Purpose of Disclosure (i.e. individual's request, insurance, continuing care, permanent transfer):

_____

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ___/___/___ (one year from request). *(initial)* _____
2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any effect on any actions they took before they received the revocation. *(initial)* _____
3. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. *(initial)* _____

By signing this Authorization, I acknowledge that I have read it and that I understand it.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

YOU MAY REFUSE TO SIGN THIS FORM