



**ORTHOPEDIC  
FOOT & ANKLE CENTER**

300 POLARIS PARKWAY, SUITE 2000  
WESTERVILLE, OHIO 43082  
OFFICE 614.895.8747 FAX 614.895.8810

**AUTHORIZATION FOR THE RELEASE OF HEALTH CARE INFORMATION**

I authorize Orthopedic Foot and Ankle Center to release the following healthcare information regarding:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Information to be released:

- Medical records (office notes, operative reports, and test results)
- X-ray Films
- MRI Films
- Entire Record

Information to be released to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

\_\_\_\_\_

**There is a charge of \$10.00 per sheet of film for X-ray duplication.**

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

*Applicable federal and state laws protect information used or disclosed pursuant to this authorization. Information that is released may be subject to redisclosure by the recipient and will no longer be protected by these laws. I understand that this authorization is voluntary and that any treatment I may seek will not be conditioned upon my signing this authorization. This authorization will expire six months after its execution.*

Thomas H. Lee, M.D.  
Gregory C. Berlet, M.D.  
Terrence M. Philbin, D.O.  
Christopher F. Hyer, D.P.M.  
Jennifer C. Swan, D.P.M.