Advance Ankle & Foot Center, LLC

9759 Fairway Drive, Powell, OH 43065 Phone: 614-792-3668 Fax:614-792-7615

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HIPPA Laws prevent us from discussing your protected health information with family or friends unless you designate the individual(s) with whom we may release information. Please complete this form to designate the individual(s) to whom we may release your protected health information. If you do not wish to designate anyone, please ✓ the appropriate box below.

Date: ______________

____

Patient's Name (Print) Date of Birth

____

Telephone Number Alternative Phone Number

I authorize Advanced Ankle & Foot Center, LLC to discuss my protected health information with the individuals listed below:

1) Name ________________________________ Relationship to Pt. _________________________

2) Name ________________________________ Relationship to Pt. _________________________

3) Name ________________________________ Relationship to Pt. _________________________

☐ Please only discuss my protected health information with me.

May we leave a message on your answering machine/voicemail? ☐ Yes ☐No

Protected health information includes the following. **Please check "NO" in each box following the medical information not to be discussed, and check "YES" in each box following the medical information that may be discussed.**

History and Physical	☐ YES ☐ NO	Pathology Report	☐ YES ☐ NO
Lab Tests	☐ YES ☐ NO	Photographs/x-ray images	☐ YES ☐ NO
Progressive Notes	☐ YES ☐ NO	Other ____________________	☐ YES ☐ NO
Operative Report	☐ YES ☐ NO		

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and may no longer be protected by federal or state law.

I understand that I may revoke the authorization in writing at any time, except to the extent that action has been taken by Advanced Ankle & Foot Center, LLC in reliance on this authorization, by sending a written revocation at the above address.

I understand I have the right to:

- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

____________________________________ ____________________________________

Signature of Patient or Patient's Personal Representative Date

____________________________________ ____________________________________

Printed Name of Personal Representative, if applicable Relationship of Personal Representative to Patient

____________________________________ ____________________________________

Signature of Affiliated Representative of AAFC Date