Ankle & Foot of Edmonds

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Proliance SURGEONS

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AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: _____ DOB: _____

Information released from:

Doctor/Facility: _____

Address: _____

Phone: _____ Fax: _____

Information to be released: __The last two years

__ All medical records

__ Specific _____
Please specify

Information to be released to:

Doctor/Facility: _____

Address: _____

Phone: _____ Fax: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give specific authorization for these records to be released.

Exclude the following information from the records released (please initial):

_____ Drug/alcohol abuse/treatment & diagnosis

_____Sexually transmitted diseases

_____HIV/AIDS treatment & testing

_____Mental or psychiatric diagnosis/treatment

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. This authorization will expire ninety (90) days from the date signed.

SIGNATURE: _____ DATE: _____
Patient, Guardian or Authorized Representative