



Desert
Foot and Ankle, P.C.

HEALTH INFORMATION RELEASE

Patient's Name: _____ Phone No. _____

Address _____ City _____ State _____

The undersigned hereby authorizes/requests Dr. _____

To provide:

Name _____

Address _____

Phone _____ Fax No. _____

With access to my medical/hospital records for the purpose of review and examination and further authorizes and requests that you provide such copies thereof as may be requested. The foregoing is subject to such limitations as indicated below.

Confined to records regarding admission and treatment for the following condition or injury

_____ on or about date _____

Covering all records for period from _____ to _____ (dates)

Confined to the following specified information: _____

No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse (Signer to initial for authentication of this response) _____

Expiration date of this authorization is one (1) year from the date of signature, unless otherwise specified. To revoke my authorization with some exceptions prior to the one year expiration, I must submit a written request to Desert Foot and Ankle. For more details on when I can and cannot revoke this authorization, I can read the provider's Notice of Privacy Practices.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient

Date

Signature of Legal Representative

Relationship to patient or description to act for patient