Elite Foot & Ankle Center

MEDICAL RECORDS RELEASE

DATE: _____/_____/_____ VALID THRU: _____/_____/_____

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

REQUESTING FROM	*RELEASING TO*
PARTY: _____	PARTY: _____
ADDRESS: _____	ADDRESS: _____
CITY:_____ STATE:_____ ZIP:_____	CITY:_____ STATE:_____ ZIP:_____

I RELEASE A COPY OF THE FOLLOWING:

COMPLETE MEDICAL RECORDS*
FACILITY GENERATED MEDICAL RECORDS ONLY
OTHER: _____

**NOTE:* IF THESE RECORDS CONTAIN ANY INFORMATION FROM PREVIOUS PROVIDERS OR INFORMATION ABOUT HIV/AIDS STATUS, CANCER DIAGNOSIS, DRUG/ALCOHOL ABUSE, OR SEXUALLY TRANSMITTED DISEASE, YOU ARE HEREBY AUTHORIZING DISCLOSURE OF THIS INFORMATION.*

FOR THE FOLLOWING DATES OF SERVICES:

ALL DATES OF SERVICE
ONLY SELECT DATES OF SERVICE: FROM _____/_____/_____ TO _____/_____/_____

FOR THE PURPOSE OF:

CONTINUING MEDICAL TREATMENT
LEGAL DISPUTE
AUTO ACCIDENT
INSURANCE REQUEST
PERSONAL USE/RECORDS RETENTION
OTHER: _____

THIS AUTHORIZATION EXPIRES 180 DAYS FROM SIGNATURE DATE UNLESS TERMINATED EARLIER

BY SIGNING BELOW I REPRESENT AND WARRANT THAT I HAVE AUTHORITY TO SIGN THIS DOCUMENT AND AUTHORIZE THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND THAT THERE ARE NO CLAIMS OR ORDERS PENDING OR IN EFFECT THAT WOULD PROHIBIT, LIMIT, OR OTHERWISE RESTRICT MY ABILITY TO AUTHORIZE THE USE OR DISCLOSURE OF THIS PROTECTED HEALTH INFORMATION.

_____ _____/_____/_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN/HEALTHCARE POWER OF ATTORNEY *DATE*