Watkins Foot and Ankle Clinic

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION:

Patient Name: _____ PT ID#_____ DOB: _____

INFORMATION TO BE RELEASED FROM:

Facility/Provider: _____

Phone: _____

Fax: _____

INFORMATION TO BE SENT TO:

Watkins Foot and Ankle Clinic

914 East Dixie Avenue Leesburg, FL 32726

Type and amount of information to be used or disclosed: (Please check all that apply)

- ☐ Complete Record
- ☐ Consultation/Office Notes
- ☐ Lab Results
  - o Date Obtained: _____
- ☐ X-Ray/Imaging Results
  - o Date Obtained: _____
- ☐ Other: _____

I understand that my heath record may include information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. My initials stand as permission to disclose the following:

_____ Substance Abuse _____ AIDS/HIV _____ Psychiatric/Mental Illness

MY RIGHTS:

I understand that, if my protected health information is disclosed to someone who is not required to comply with the Federal Privacy Protection Regulations, then such information may be re-disclosed and would no longer be protected. I understand that I have the right to revoke this authorization at any time. My revocation must be in writing, in the form of a letter. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

This authorization will expire 90 days from the date signed