ST. LOUIS FOOT AND ANKLE INSTITUTE

Authorization to Release Information to Other Parties

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the result of tests, procedures, and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize St. Louis Foot and Ankle Institute, LLC to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

- □ I authorize you to speak with the above individuals or leave a detailed message on my home or cell number regarding medical treatment, care, test results, billing or financial information.
- □ I authorize you to leave a message on my voicemail or with anyone who answers the phone.
- □ Messages may only be left with: _____

_____ _____

Patient or Authorized Representative Signature Date