Authorization For Release of Medical Information

Patient Name: _____
First Middle Last

Date of Birth: _____ Social Security Number: XXX-XX-_____

I hereby authorize _____
to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this information may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that this authorization for release of information is valid for 60 days from the date of signature, unless revoked by written notice to the providing institution. If I choose to revoke this authorization, I understand that it will not have any effect on actions taken before receipt of my revocation.

I hereby authorize the release of the following information to:

Foundation Foot & Ankle, LLC
2620A North Wooster Ave.
Dover, Ohio 44622

Fax# (330) 364-3720

Specific Information to be released: *Recent Office Notes from Patient Visits, Lab & Imaging Reports*

Purpose of Disclosure: _____

_____
Printed Name / Signature of Patient Date

_____
Printed Name/Signature of Parent or Legal Representative Relationship to Patient Date

_____
Printed Name / Signature of Witness

For any questions regarding this fax call (330) 364-7546