*** ***This form is to release information from our office to another Doctor*** ***

The Center For Foot & Ankle Surgery
1015 E. 32ND St Suite 212
Austin, TX 78705
Phone: 512-477-8853 Fax 512-477-2592

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize The Center for Foot & Ankle Surgery, P.A. to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient Name: ______________________________ DOB: ________________

Phone #: ____________________ Social Security #: ______________________

Address: ____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** ________ **Date:** _________

Limitations on the information you may release subject to this release are as follows:

____

____

____

Date(s) the release is good for: From: ______________ To: ______________

Release my protected health information to the following person(s)/entity:

Name: ____

Street: ____

City: ____________________________ State: ________ Zip: ____________

Phone: ______________________ Fax: __________________________

The reason or purpose for this release of information is as follows: ______________________

____

______________________________________ ____________________

Patient Signature/legal representative Date

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

(Please complete in full or request will be returned to you)

Patient Name: ______________________________ **Phone:** ______________________

Address: ____

Social Security # _____-_____-______ **Date of Birth:** _____/______/_____

I the undersigned, hereby authorize:

Doctor / Facility: ____

Address: ____

Telephone: (____) ______-_________ **Fax:** (____) _______-__________

To disclose information relating to my medical records to:

The Center for Foot & Ankle Surgery, P.A.
1015 E. 32nd St Suite 212
Austin, TX 78705
Phone (512) 477-8853 **Fax: (512) 477-2592**

Reason for disclosure: ____

Records to be released: **Complete Chart** _____ **Immunization Records** _____
Specific Dates _____ From: ___/___/___ To: ___/___/___ **Lab Reports** _____
Other: ____

By Signing below, I hereby consent and authorize the release of my medical records, including current and past records. I understand that this authorization includes consent for the release of information relating to my medical treatment, including psychological or psychiatric conditions, drug abuse, alcoholism, HIV related information (AIDS related testing), cancer testing and results or information protected to State and Federal Laws as related to a minor. I agree that a copy of this release shall be valid as this original. I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically 1 year (365 days) from the date indicated below.

Note: FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION

Signature of Patient or Legal Representative and Relationship to Patient

____ **Date:** ______________