HARRISBURG FOOT AND ANKLE CENTER, INC.
AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

_____

I request and authorize Harrisburg Foot and Ankle Center, Inc. to release healthcare information of the patient named above to: _____

on behalf of _____

This request and authorization applies to:

_____Medical records needed for continuity

_____Laboratory reports

_____X-rays

_____Clinician office chart notes

_____Emergency and urgency care notes

_____Billing statements

_____All reports

_____Sensitive materials (See Below)

_____Other: _____

_____

This information is being requested for the following purposes: _____

_____

Please release records for the dates of: _____

Note on "Sensitive Materials": Sensitive materials may include, but is not limited to any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If "Sensitive Materials" has been checked, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

I have read and understand the following:

- This authorization is valid for 90 days after the date it is signed.
- A photo-static copy is as valid as an original.
- This authorization is revocable at any time upon written notification to the custodian of records.
- Although prohibited, it is possible that my PHI (Personal Health Information) may be re-disclosed by the facility receiving my records, therefore the provider has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA privacy rule.

_____

Signature of Patient or Personal Representative Date Signed

_____

Relationship of status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)