COLORADO FOOT AND ANKLE

MEDICAL RECORD RELEASE FORM

Patient: _____ Date of Birth: _____

Address: _____ SSN: _____

_____

In compliance with HIPAA standards, I hereby authorize my medical records to be released as shown below:

FROM:

Name: _____

Address: _____

Telephone #: _____

Fax #: _____

TO:

Name: _____

Address: _____

Telephone #: _____

Fax #: _____

Requested Information (circle all that apply)

All Records

X-ray/ Radiology records

Pharmacy/ Prescription records

Laboratory/ Pathology records

Billing records

Specific dates: from _____ to _____

Other (specify): _____

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*This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

_____ _____

Signature of Patient or Legal Guardian Date Signed

Bryan Groth, DPM Eric Gessner, DPM Jacob Fassman, DPM Maya Trueman, DPM

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