Premier
FOOT & ANKLE CARE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME	DATE OF BIRTH	LAST 4 of SS#
_____	_____	_____

I hereby authorize Premier Foot & Ankle Care to use and disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that it may include information relating to **AIDs, HIV Infection, behavioral health services, psychiatric care, and treatment for alcohol and/or drug abuse.** I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by Federal Privacy Regulations. I understand that I need not sign this authorization to ensure treatment and that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules.

1.) I give permission to the staff and physicians of Premier Foot & Ankle Care. to leave detailed phone messages at the following number: _____

2.) Premier Foot & Ankle Care can share the following protected health information with the people listed below:

☐ **ALL**

☐ Consultation Reports ☐ Laboratory Results ☐ Radiology Images

☐ Discharge Summary ☐ Progress Notes ☐ Referral Information

☐ History and Physical Examination ☐ Radiology Reports ☐ **DECLINED ALL**

Name and Relationship To Patient	Phone Number

I certify that I have read the provisions of this authorization, understand the content, and agree to the terms set forth within the authorization. I understand that this authorization is valid for one year from signature date unless there is a Power of Attorney or Durable Healthcare Power of Attorney on file in my record.

_____ _____/_____/_____

Patient Signature Date