FAMILY FOOT & ANKLE PHYSICIANS, PLLC

J. Scott Stancil, DPM Amy M. Pitzer, DPM Rick C. Chen, DPM Aaron J. Leshikar, DPM
1432 E. Fire Tower Road, Greenville, NC 27858
P (252) 439-1150 F (252) 439-1152

AUTHORIZATIONTO REQUEST/RELEASE MEDICAL RECORDS

Please complete the following Information:

Date: _____ Acct # _____

Patient Name: _____

Address: _____

Phone: _____ Date of Birth: _____/_____/_____

The above listed patient authorizes the following healthcare facility to make the following record disclosure:

O All records O Billing records O X ray/radiology records O Records on CD (Disk) $20 Fee
O Laboratory/pathology O Pharmacy/prescription records Other (specify)_____

O **From Facility:**
Name: _____
Address _____
Phone: _____
Fax: _____

O **Release to:**
Family Foot & Ankle Physicians, PLLC
1432 E. Fire Tower Road
Greenville, NC 27858
P (252)439-1150 F (252)439-1152

O **Release From:**
Family Foot & Ankle Physicians, PLLC
1432 E. Fire Tower Road
Greenville, NC 27858
P (252)439-1150 F (252)439-1152

O **To Facility/Patient**
Name: _____
Address: _____
Phone: _____
Fax: _____

These records are for services provided on the following date(s): _____

Note: if these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information. I understand that after the custodian of records discloses my health information, it may not longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. This authorization shall not be valid for greater than one year from the date of signature.

_____ _____

Signature of patient (or patient's personal representative) Date

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OFFICE USE ONLY

Completed By: _____ Date Records Picked up / Faxed / Mailed: _____