FAMILY FOOT & ANKLE PHYSICIANS, PLLC

J. SCOTT STANCIL, DPM   AMY M. PITZER, DPM   RICK C. CHEN, DPM   BRIAN L. JONES, DPM

1432 East Fire Tower Road   Greenville, North Carolina 27858   (252) 439-1150

AUTHORIZATION TO 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   **O**ther(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

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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 no 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

*Description of Personal representative's authority (attach necessary documentation)

☐ Revoked by patient or personal representative on _________________________

DATE

How revoked: **O** orally (in person or via phone)   **O** in writing (place copy in patient's file)

OFFICE USE ONLY:

Completed by: ____________________   Date Records Picked up/faxed/Mailed: ___________________