FAMILY FOOT & ANKLE PHYSICIANS, PLLC
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DEMOGRAPHICS & AUTHORIZATIONS FOR RELEASE

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Mailing Address: _____

City: _____ St: ___ Zip: _____ Email:_____

Billing Address: _____

City: _____ St: ___ Zip: _____

Gender: M F Ethnicity: _____ Marital Status: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Carrier(s): _____

Family Foot & Ankle Physicians, PLLC is authorized to release protected health information (PHI) about the above-named patient in the following manner.

Allow our office to release information to you through the following communication preferences:

☐ Leave me a voicemail on the numbers provided above
☐ Send me an *email that is posted above ☐ Send me a *text on my mobile device
☐ *For **email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Allow our office to send you the following information through the communication preferences you have selected above: ☐ Financial ☐ Medical records and results ☐ Appointment reminders ☐ Legal/Insurance

Allow the following persons/entity to receive protected health information (PHI) regarding my health care.
This section can be left incomplete & changed if you decide to allow someone to receive your records in future.

Person or Entity	Person Date of Birth	Phone	Email

Patient's Rights:
- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed because of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this document

This authorization will remain in effect unless revoked by the patient.

Signature of Patient or Personal Representative: _____Date: _____