Family Foot & Ankle Physicians, PLLC

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AUTHORIZATION TO REQUEST/RELEASE MEDICAL RECORDS & FORMS

Today's Date: _____
Patient Name: _____ **Date of Birth**: _____/_____/_____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **Email:** _____

SECTION A: Which healthcare facility needs to release your records?

O I need Family Foot & Ankle Physicians to send my records to another facility (Please list below)
O I need my provider to send my records as indicated in Section B below. (send this form to your provider)

Other Facility Information
Name: _____
Address: _____
City,St,Zip: _____
Phone : _____
Fax : _____

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SECTION B: Select the type of records requested.

O Patient Office Visits (includes x-ray assessment, but no image) **O** Billing records **O** X-ray/radiology images
O Laboratory/pathology **O** Pharmacy/prescription records **O O**ther(specify) _____

Please indicate what time frame of medical records you are requesting. If all, select All Record Dates below.

From Date: _____ To Date: _____ **O** All Record Dates

SECTION C: Medical Record/Forms Processing Fees:

Select the method in which you need Family Foot & Ankle Physicians to release records only.

O For Doctor to complete forms, such as FMLA, Disability, etc. $15.00
O Electronic Fax $0.00 **O** Email $0.00 *(*note this is not a secure method)*
O Direct Mail: **O** $2.50 if it fits in a small manilla envelope for postage.
O $25.00 down payment on records needing boxed. Other postage fees may be assessed.
O Portable Device: **O** $10.00 for 32gb device **O** $25.00 for 128gb device **O** $5.00 if small enough to fit on CD
All X-Rays must be placed on a Portable Device as it is not a printable document.
O Patient Portal: $0.00. There is no fee to create an account and see your records. However, the billing and x-ray records are not on our patient portal. To access our portal, go to our website and select Patient Resources.
O Pick Up: I can pick up my records from Family Foot & Ankle once processed. If fees are associated above, then payment is required at time of pick up.

*For **email communication** I understand that information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive my medical records through email communication as selected.
If Choosing Email Method, Sign Here: _____

SECTION D: SUBMITTING THIS FORM TO FAMILY FOOT & ANKLE PHYSICIANS

Find Me: X: Front Desk Forms

- In Person: Hand this form back to the front desk team at either location (building 1 or 2)
- Email: If you signed the email communication disclaimer above, then you can email this form to manager@FFAPNC.com
- Fax: Send to fax number 252-439-1152
- Mail: Mail this form the address in the header of this form.

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

SECTION E: TO AUTHORIZE A FAMILY MEMBER OR OTHER CAREGIVER

Allow our office to send your caregiver the following information:

☐ Financial ☐ Medical Records and Results ☐ Appointment Reminders ☐ Legal/Insurance

Allow the following person(s)/entity to receive protected health information (PHI) regarding my health care.

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 patient's personal representative) Date

SECTION F: OFFICE USE ONLY:

Completed by: _____ Date Records Picked up/faxed/Mailed: _____

Find Me: X: Front Desk Forms