SILVERMAN
ANKLE & FOOT

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1| **Patient Information:**

Name: _____ Previous Name(s):_____

Address:_____ Date of Birth: _____

_____ Phone: _____

2| **I am requesting that health information be sent to:**

I hereby authorize, and request that the above facility/provider release copies of my medical information that are created and maintained by their facility to:

Release from/to:_____

Address:_____ City: _____State:_____ Zip:_____

Phone:_____ Fax:_____ Additional Info:_____

3| **Body part(s) and/or dates of service requested:** _____

Information to be released:
Important: indicate only the information you are authorizing be released.

☐ Medical Records ☐ HIV/Mental Health/Drug Abuse Records

☐ Itemized Billing ☐ X-ray (CD/Films)

☐ Operative Note ☐Other _____

☐ *Verbal disclosure of medical information-Please check here if you are completing this form for verbal communication consent only to the individual listed above in section 2*

4| **Reason for releasing information**:

☐ Insurance ☐ Worker's Compensation ☐ Disability

☐ Legal ☐ Treatment/Continued Care ☐ Patient's Personal Use

5| **Information needs to be received by:** Date:_____

(please allow 2 weeks for transfer)

I would like to received my records by:

☐ Fax:_____ ☐ Pick up ☐ Mail: *(postage pre-payment may apply)*

I hereby authorize and request that Silverman Ankle & Foot release my health information that is created and maintained by SAF. I understand that I may revoke this consent at any time in writing. Revocation becomes effective once written request is received by SAF. This authorization will automatically expire in one year from the date of signing. I understand that I will not be refused treatment if I choose not to sign this authorization. I realize that the above stated medical facility cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to the privacy rule protections.

6| **Signature of Patient/Guardian***: _____ **Date**:_____

**If signed by person other than patient, please send copies of legal documentation for representation*

INSTRUCTIONS FOR RELEASE OF MEDICAL INFORMATION AUTHORIZATION FORM

Silverman Ankle & Foot strives to protect each patient's confidential medical information.
All sections of the Silverman Ankle & Foot release form need to be completed legibly.
Incomplete or illegible forms may result in delay or denial of the request.

1| SECTION ONE:

- Please fill in the patient's **full legal name**, complete **mailing address** and **date of birth.**
- Please provide a **phone number** where the patient can be reached for any questions or concerns regarding their request.

2| SECTION TWO:

- This section indicates **where the medical information for the patient needs to be sent**.
- **Only ONE person or entity may be listed in this section**. Please use a separate form to release records to additional parties.
- Patients requesting records for themselves may simply just put 'self' or 'patient' on the top line of this section.
- If medical information needs to be sent **to another clinic or provider**, the name of that clinic or provider must be listed, along with the full mailing address, phone number and fax number.
- If medical information needs to be **released to an attorney or insurance company**- the requesting party needs to submit a formal request from their office. Please contact this company directly.

On the line, '*Additional Information,'* you may put any information that may help in assisting us in processing the records request.

3| SECTION THREE:

Please fill in the line that asks what **body part or date(s) of service** that needs to be disclosed. This assists us in accurately fulfilling the records request and releasing the proper information.

- **Please check the boxes** to indicate what needs to be sent to the person or entity listed in SECTION TWO.
- **Verbal Disclosure** - If this release is being filled out for *VERBAL COMMUNICATION* only the person or entity listed in SECTION TWO, may receive verbal information. *Please note that this is for VERBAL communication only and no physical information will be released (i.e.: hard copies of medical records).*

4| SECTION FOUR:

Please indicate, by checking the appropriate box, the **reason for this request**.

- For patients requesting records for themselves, check *Patient's Personal Use. If mailed, person requesting is responsible for pre-payment of postage. A pre-payment request letter will be sent to requesting party.*
- For x-rays going to another clinic or provider*, the first copy will be free of charge. If mailed, person requesting is responsible for pre-payment of postage. There will be a fee for subsequent copies and a pre-payment request letter will be sent to requesting party.*
- For records going to another clinic or provider, check *Treatment/Continued Care.*
- As noted in section two, requests for: *Insurance, Legal, Worker's Compensation* or *Disability* need to be requested directly from the corresponding entity.
- **The first copy of records (up to 25 pages if printed and 3 CDs for x-rays) is free of charge. Subsequent copies require pre-payment.**

5| SECTION FIVE:

- Please allow up to two weeks for the transfer of medical information.
- Requests will only be **rushed** for the purposes of treatment/continued care.
- Please indicate on the *'Date'* line when the records **need to be received by** & we will try to accommodate your request.

The requested medical information **can be e-mailed, faxed, picked-up in person,** or **mailed**.

- **E-mail** - Please write the e-mail address legibly on the release form.
- **Fax** - Please list the fax number.
- **Patient Pick-up**- ONLY the patient or guardian can pick up the records. The request must list the patient in SECTION TWO.
- **Mail** – Pre-payment for postage is required.
- **Please note that transmition via email or fax is not secure & a third party could gain access to your records.**

6| SECTION SIX:

Signature of the patient* AND date of signature are required in this section.

- If the patient is a **minor** (under 18 years of age) a parent or legal guardian needs to sign and date the form.
- If the form is signed and dated by a legal representative *(i.e.: POA)*, please include legal documentation when submitting the form.
- This authorization is valid for one year from the date of signature. The patient may revoke this authorization in writing.