RELEASE OF INFORMATION

I hereby authorize Foot and Ankle Center of Iowa to disclose and/or receive my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that my health information MAY INCLUDE information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and/or treatment for alcohol and/or drug abuse. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found below, but if I do it will not affect any actions taken before receipt of my revocation. I understand that limiting or revoking authorization to share medical information with your insurance provider may lead to denial of payment and I will be responsible for all unpaid charges.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for treating protected health information for disclosure to a third party.

Patient Name_____ **Date of Birth** _____

Who is to disclose the information	◯ Foot and Ankle Center of Iowa ◯ Name_____ Address _____ City, State, Zip _____ Phone _____Fax _____
Who is to receive the information	◯ Foot and Ankle Center of Iowa ◯ Name_____ Address _____ City, State, Zip _____ Phone _____Fax _____
What information should be sent	◯ Entire Medical Record- medical documentation, lab, tests, & radiology results ◯ Records dating from _____to _____ ◯ Radiology Images/reports ◯ Progress Notes ◯ Labs ◯ Billing Statement ◯ Operative Reports ◯ Other _____
Purpose of the request	◯ Transfer of medical care to another provider ◯ Other _____

I specifically authorize the release of records that may include protected information. Yes or No **must** be checked for each of the following:

Mental Health ◯ Yes ◯ No **HIV/AIDS testing** ◯ Yes ◯ No **Substance abuse treatment** ◯ Yes ◯ No

_____

Patient/Guardian or Representative Signature Printed Patient Name Date

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contact@footanklecenteriowa.com