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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____DOB: _____ Phone #: _____

Records From:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

Send Records To:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

My authorization extends only to those date elements / documents initialed below:

__ Complete Medical Records (All progress notes, labs, imaging, pathology, etc..)
__ Medical Record(s) for visit for a specific date or dates: _____
__ X-rays, photographs, videotapes, digital or other images with Reports
__ All Labs / Pathology
__ Hospital Discharge Summary/ Hospital History and Physical Examination/ ER Records
__ Other (Must be specific) _____
__ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
__ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if notified below.
4. **Star Foot & Ankle Specialists, Gary Heredia, D.P.M and Morgan Zellers, DPM,** its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
PATIENT'S NAME - PRINTED DATE

_____ _____
PATIENT'S SIGNATURE (OR GUARDIAN IF A MINOR SS or DL # with State

_____ _____
WITNESS Date