Da Vinci
FOOT & ANKLE

PHI Release Authorization

1.15.18

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Da Vinci Foot and Ankle to disclose the following information from the health records of:

Name: _____
Last First MI Previous Name

DOB: _____Social Security#: _____Telephone: (M)_____(W)_____

Address: _____
Street City State Zip

This information is to be disclosed only to: _____

Address: _____
Street City State Zip

Format: _____ Paper _____ Electronic All Dates: _____ Dates of service: From _____ to _____

For the purpose of: _____

The following information may be released:

☐ Entire Medical Record ☐ Copies of Radiographs ☐ MRI and Report ☐ Lab Results ☐ Operative Report ☐ Pathology Reports

☐ Other: _____

I understand this will include information relating to (check and initial, if applicable):

_____ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.

_____ Behavioral health service/ Psychiatric care / Psychotherapy notes

_____ Treatment for alcohol and/or drug abuse.

Affirmation of Release: I give the practice permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient, I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

_____ _____
Signature of the Patient/Guardian/Legal Representative Date Signed

_____ _____
Signature of Witness/Relationship to Patient Date Signed

Expiration date: _____ (Default is one year from date signed)