AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name:_____Medical Record No._____

Address: 500 Old River Road STE 185 Bakersfield, CA 93311

Facility Name: _____

I authorize **Bakersfield Foot and Ankle Surgeons** to use or disclose my health information as described below.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

- ❑ Only the following records or types of health information:

_____

_____

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize Bakersfield Foot and Ankle Surgoens to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name :_____ Relationship _____
Address _____ Phone #_____

Name :_____ Relationship _____
Address _____ Phone #_____

Purpose: I authorize the release of my health information for the following specific purpose:

_____

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Term: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the_____day of_____, 20 _.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

Authorization Statements/Signatures:

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Distribution of copies: Original to patient's Medical Record, copy to patient.