AKAMAI FOOT DOCTOR, LLC

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

ATTN: **"*"** Items MUST be completed for authorization to be valid.

***I authorize** * _____*
to release the protected health information of:

***Patient Name:** _____ Date of Birth: _____

Phone #: _____

***to*: _____

Address: _____

Tel: _____ Fax: _____

*Information to be disclosed:	*Purposes for Use and/or Disclosure: (check as many as apply)
[ ] All medical records **[ ]** Lab/Imaging Reports **[ ]** Clinical notes **[ ]** X-ray Film(s) **[ ]** HIV test results **specify** ( ) Yes ( ) No **[ ]** Restrict to the following dates/conditions: _____ _____ **[ ]** Restrict to information necessary to complete form provided **[ ]** Other (specify) _____ _____	☐ At the request of the individual ☐ Legal Purposes ☐ Insurance ☐ Physician follow-up ☐ Other _____ _____

_____ (initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services. (If I do not specifically agree, this information will not be disclosed.

***Unless otherwise revoked, this authorization will expire on the following date or event: _____.**
If a date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Akamai Foot Doctor, LLC, nor will it affect my eligibility for benefits.

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (e.g., a letter) addressed to Akamai Foot Doctor, LLC**.** I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I hereby release Akamai Foot Doctor, LLC from all liability and all claims of any nature whatsoever pertaining to disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Akamai Foot Doctor, LLC. I certify that I have received a signed copy of this authorization.

I understand that I will be assessed a flat fee of $25 for this service and $1.00 for each page thereafter, including toner copies of x-rays. If delivery is requested, I understand that I am also responsible for shipping costs at a minimum of $5.00 for first class mail. Doctor-to-doctor requests are processed without charge if shipping charges do not apply. Please allow 30 days to process request, beyond delivery time.

Requestor _____ _____

*** Signature** *** Print Name**

Relationship: _____ _____

*** Relationship to Patient** (Complete only if Requestor is not patient) *** Date**