

# West Coast Foot & Ankle

Associates Inc

Troy R. Leaming, DPM Kazuto H. Augustus, DPM Richard L. Bell DPM

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## MEDICAL RECORDS RELEASE AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Please complete the following information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize the release of records from:

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regarding the following information (Check all Applicable)

- All Records
- Lab/Pathology Records
- X-ray # of Films \_\_\_\_\_
- Billing Records
- Other \_\_\_\_\_

**\*\*\*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.**

these records are for services provided on the following date(s):

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Please send the records listed above to:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Fax: \_\_\_\_\_

The information may be used/disclosed for each of the following purposes:

- At my request
- For my Healthcare
- For payment/insurance
- For employment purposes
- Other: \_\_\_\_\_

By signing below I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

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Signature of Patient (or Patient's Legal Guardian)

Date

**THIS AUTHORIZATION SHALL EXPIRE IN 30 DAYS FROM DATE SIGNED**

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6552 BOLSA AVE., STE H  
HUNTINGTON BEACH, CA 92647  
OFFICE 714.897.9551  
FAX 714.893.6519

1760 TERMINO AVE., #309  
LONG BEACH, CA 90804  
OFFICE 562.986.6886  
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