West Coast Foot & Ankle

Associates Inc

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

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:

_____

regarding the following information (Check all Applicable)

- o All Records
- o Lab/Pathology Records
- o X-ray # of Films_____
- o Billing Records
- o 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):

_____

Please send the records listed above to:

Name:_____
Address:_____
_____
Phone:_____
Fax:_____

Name:_____
Address:_____
_____
Phone:_____
Fax:_____

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

- o At my request
- o For my Healthcare
- o For payment/insurance
- o For employment purposes
- o 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.

_____

Signature of Patient (or Patient's Legal Guardian) Date

THIS AUTHORIZATION SHALL EXPIRE IN 30 DAYS FROM DATE SIGNED