AUTHORIZATION TO RELEASE INFORMATION FROM MOORE FOOT AND ANKLE SPECIALIST

Patient: ____DOB: ______________________________

☐ I hereby authorize to use or disclosure of protected health information for the purpose of:

☐ Continuity of Care ☐ Insurance Request
☐ Treatment ☐ At the request of the patient
☐ Legal Investigation/Action ☐ Other_______________________________

TO: ____

Address: ____

Phone: ____Fax: ____________________________________

Email: ____

Information to be disclosed:
☐ Entire Medical Record ☐ Surgery Records
☐ Radiology film or images ☐ Billing Record
☐ Other: ____

AUTHORIZATION TO RELEASE INFORMATION TO MOORE FOOT AND ANKLE SPECIALISTS

☐ I hereby authorize to use or disclosure of protected health information for the purpose of continuity of care and treatment to: ☐ Robert J. Moore III, DPM ☐ Eric Blanson, DPM

Moore Foot and Ankle Specialists
21309 Foster Road, Suite 200, Spring, TX 77388
Tel. 281.444.6300 Fax: 832.375.1247

Information to be disclosed:
☐ Entire Medical Record ☐ Surgery Records
☐ Radiology film or images ☐ Billing Records
☐ Other: ____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I am giving authorization to use, disclose, or exchange my health information. I understand that I may be charged a fee for record copies. I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the privacy officer in writing. I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and may not be protected by federal privacy regulations. I understand that this authorization will not expire unless I submit in writing to the privacy officer.

Signature: ____ Date: ________________________

Witness: ____Title: ________________________