Authorization for VPC to **Receive** Medical Records

VILLAGE PODIATRY CENTERS
EXCELLENCE IN FOOT & ANKLE MEDICINE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Medical Records
900 Circle 75 Ste. 900
Atlanta GA, 30339
770-771-6753 Phone
678-426-2205 Fax

I HEREBY REQUEST A COPY OF THE FOLLOWING PATIENT'S MEDICAL RECORD:

1. **Full Name of Patient:** _____
2. **Maiden Name/Alias:** _____
3. **Patient's Birth Date:** _____ **MR#** _____

******Please Note: Copy Fee May Be Charged For Medical Records *******

4.

( ) Face Sheet	**( ) Laboratory Reports**	**( ) Progress Notes**
( ) History & Physical	**( ) X-Ray Reports**	**( ) Physicians' Orders**
( ) X-Ray	**( ) Nurses' Notes**	**( ) Pathology**
( ) Entire Chart	**( ) Detailing Billing**	**( ) Consultations**

( ) Other (Please specify clearly)* _____

5. **Identify date of service or date ranges requested including month and year**: _____

6. **Entity or individual <u>authorized to Release</u> the Protected Health Information:**

Name & Title: _____

Street Address: _____

City/State/Zip: _____ **Phone Number:** _____ **Fax Number:** _____

7. **Entity or individual <u>authorized to Receive</u> the Protected Health Information:**

Name & Title: Village Podiatry Centers - Any Location

Street Address: 900 Circle 75 Parkway, Suite 900

City/State/Zip: Atlanta GA, 30339 **Phone Number:** 770-771-6753 **Fax Number:** 678-426-2205

8. **THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):**
( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes ( ) Personal Interest
( ) Other (Specify) _____

9. I understand that I may revoke this authorization at any time by providing written notice of my intent to revoke this authorization to Extremity Healthcare/Village Podiatry Centers. I understand this authorization cannot be revoked to the extent that action has already been taken in reliance on the authorization prior to the Center receives my written request to revoke authorization. This consent will expire in 12 months after the date below or upon the earliest of the following to occur: (1) the termination of my association with either Extremity/Village Podiatry Centers or the Recipient; (2) the termination of the affiliation between Extremity/Village Podiatry Centers and the recipient; or (3) my revocation of this authorization.

I understand that I may refuse to sign this authorization. I understand that Extremity/Village Podiatry Centers will not condition the commencement or continuation of treatment on my decision as to whether to provide this authorization, nor would my refusal to sign this authorization affect any payment, enrollment or eligibility for benefits from any source.

Extremity/Village Podiatry Centers will not use or disclose personal health information beyond the scope of this authorization without my written consent or authorization. I understand that disclosed information may be subject to re-disclosure by the recipient, and no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder

I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

10. **Signature:** _____ **Date:** _____
Patient, Parent or Legally Authorized Representative

Relationship to the Patient: _____

Phone Number: _____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentially is protected by federal and/or state law. Federal and state regulations prohibit you (the recipient) from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. DL022017