HIPAA Privacy Authorization Form – To AFS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I _____ DOB_____

authorize _____

to release my protected health information described below to:

Associated Foot Surgeons of Southwest Illinois
2900 Frank Scott Parkway West, Suite 900
Belleville, Illinois 62223
(618) 277-5700

Specific information to be released/disclosed from_____ to _____ specified below:

( ) Complete Medical Records OR ( ) Specify one or more of the following:
( ) Operative Reports
( ) Clinic Notes
( ) Laboratory
( ) XRays (Disks are $20, due upon receipt)
( ) Billing and Claim Records
( ) Other (Specify)_____

This authorization expires on _____.

____I authorize the release of my complete health record with the exception of:

____Mental health records ____Communicable diseases
____HIV or AIDS ____Alcohol/drug abuse treatment
____Other (Specify):_____

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Print Full Name Date

_____
Signature of Patient, Parent or Legal Guardian