PATIENT AUTHORIZATION OR REVOKE FOR RELEASE OF INFORMATION

Patient Name (print): Date of Birth:

AUTHORIZATION or REVOKE RELEASE OF INFORMATION

❑ I hereby authorize Associated Foot Surgeons, it's representatives, physicians and staff to release:

❑ All medical, ❑ All financial information to the following individual(s): _____Your Initials

❑ Specific medical, ❑ Specific financial information pertaining to the following dates: _____to _____ to the following individual(s): _____Your Initials

❑ This authorization is for the following time period: _____ to _____

❑ I hereby revoke authorization for the following individual(s): _____Initials

1. Name:_____Relationship:_____

   Home Phone: _____Work Phone: _____Cell Phone:_____

2. Name:_____Relationship:_____

   Home Phone: _____Work Phone: _____Cell Phone:_____

- **I understand that this authorization is voluntary and that I can refuse to sign this authorization. I do not have to assign a person to receive care.**
- **I may revoke this authorization at any time.**

I hereby understand and agree with the information I have provided above.

PATIENT'S SIGNATURE: _____

PARENT OR AUTHORIZED REPRESENTATIVE (If applicable) : _____

☐ Parent ☐ Legal Guardian ☐ Other: _____ Date: _____

MESSAGE AUTHORIZATION

❑ I hereby authorize Associated Foot Surgeons, it's representatives, physicians and staff to leave message(s) related to my healthcare on a recorder at the following phone number(s):

❑ I hereby revoke authorization to leave messages on the following phone numbers:

1. Home Phone: _____Work Phone: _____Cell Phone:_____

2. Home Phone: _____Work Phone: _____Cell Phone:_____

- **I understand that this authorization is voluntary and that I can refuse to sign this authorization. I do not have to sign this form to receive care.**

I hereby understand and agree with the information I have provided.

PATIENT'S SIGNATURE: _____

PARENT OR AUTHORIZED REPRESENTATIVE (If applicable) : _____

☐ Parent ☐ Legal Guardian ☐ Other: _____ Date: _____