

# AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, \_\_\_\_\_ Who resides at \_\_\_\_\_ in the  
city of \_\_\_\_\_ in the state of \_\_\_\_\_ hereby authorize:

**RECORD  
HOLDER**

Name: WACO FOOT & ANKLE, P.A.  
Address: 201 COLONNADE PARKWAY, SUITE 100  
City: WOODWAY State: TEXAS Zip: 76712

to disclose the following specific medical information by:  Mail  Fax  E-mail  Verbal to:

**INTENDED  
RECIPIENT**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

from the Health Records of:

**PATIENT'S  
NAME**

Patient's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

My authorization extends only to those data elements/documents initialed below:

- |  |  |
|--|--|
| _____ Statements/Receipts of Charges or Payments   | _____ Progress Notes                                   |
| _____ Records of Visits (All Visits)   | _____ Photographs, videotapes, digital or other images |
| _____ Record of Visits for Specific Date or Range of Dates<br>*Specific dates include or are limited to: _____ | _____ Discharge Summary                                |
| _____ Copies of records or reports provided to the above named<br>(i.e. hospital, lab, clinic, etc)            | _____ History and Physical Examination                 |
|  | _____ Insurance Information                            |
| _____ <b>ALL THE ABOVE</b>   |  |

The following items require specific authorization in order to be disclosed:

- \_\_\_\_\_ Mental Health and/or Alcohol and Drug Abuse Treatment  
\_\_\_\_\_ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information  
\_\_\_\_\_ Hepatitis Information

**This authorization is given freely with the understanding that:**

1. Any & all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Waco Foot and Ankle, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability from disclosure of the above authorized information to the extent indicated herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ Patient's Name Printed	_____ Date	_____ Patient's Social Security Number (for identification purposes)
_____ Patient's or Personal Representative's Signature (Guardian If A Minor)	_____ Expiration Date If Other Than 1 Year	
_____ Patient's Personal Representative's Name Printed	_____ Date	_____ Witness Name Printed
_____ Patient's Personal Representative's Authority To Act		_____ Witness' Signature