Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name _____ (Last, First, Middle/Maiden)

Patient's Address: _____ City _____ State _____ Zip_____

Date of Birth _____ Phone Numbers_____

I authorize my physician and/or administrative and clinical staff at Tallahassee Podiatry Associates or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	**Person or Entity to Disclose Information:**
Name/Organization: _____	Name/Organization: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

__ Complete Medical Record __ Billing Records __ Office Notes __ X-rays (CD)

__ Lab Reports __ Surgery Records __ Other (specify): _____

DATES OF SERVICE: _____

PURPOSE: ___ Changing Physicians ___ Personal Copy to Patient ___ Attorney ___ Insurance ___ Workers' Comp.

Other _____

This authorization will expire on: _____ (If no date is specified, it will expire 60 days after date signed).

I have read and understand the nature of this authorization and I have been provided a copy of TPA's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at Tallahassee Podiatry Associates, P.A., 1866 Buford Blvd, Tallahassee, Florida 32308, Attn: Administrator or email rgs@tlhpodiatry.com.

I understand that a revocation is not effective to the extent that my physician or Tallahassee Podiatry Associates has taken action in reliance upon this 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 also understand that such revocation does not affect TPA's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ _____

Signature of Patient or Patient's Representative Witness

_____ _____

Relationship to Patient Date

(If applicable, attach document of guardianship or Power of Attorney)

TALLAHASSEE PODIATRY ASSOCIATES FOOT & ANKLE CENTER

Dr. George N. Merritt
Dr. Russell W. Rowan
Dr. Bryan A. Spooner
Dr. Joshua A. Nichols