Sarasota Foot and Ankle Center

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Authorization to Release Medical Records

I, _____ DOB: _____

Hereby authorize **Sarasota Foot and Ankle Center** to
(Check one option please)

( ) release copies of my medical records to:
_____.

( ) obtain all of my records.

For the purpose of fully evaluating my health and to make informed decisions. Please include the following protected information in addition to my general health information:

( ) All labs and imaging studies
( ) Sexually transmitted diseases
( ) Office Notes and Surgery Reports
( ) Alcohol and/or drug abuse
( ) AIDS/HIV testing
( ) Psychiatric / mental health

To/From:

_____
Name of Physician or Facility

_____
Complete Address

YOUR RIGHT WITH RESPECT THIS AUTHORIZATION

I understand that I must be provided with a signed copy of this authorization. I understand that written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Dr. Dawn Chiu/Dr. Arthur Clode will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Dr. Dawn Chiu/Dr. Arthur Clode will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person/s and/or organization/s listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be re-disclosed without obtaining my authorization. I understand that I may be charged a fee for the copying of these records.

_____ Date:_____
Patient's signature or authorized party's signature

_____ Date:_____
Witness signature