



Authorization for Use or Disclosure of Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize First Step Foot Care (FSFC) to release/disclose individually identifiable health information relating to me to each of the following. Please check all that apply.

Spouse     Mother     Father     Children     Other

Name: \_\_\_\_\_

May leave results on answering machine                      Yes                      No

I authorize the release of the following. Please check all that apply.

Entire medical record     Lab results     X-ray results     Referrals  
 Prescriptions

This information is being released at the request of the patient:

- I understand that if the person or entity that receives this information is not a health plan or health care provider, the released information may be re-disclosed by the recipient and may no longer be protected by the federal or state law.
- I understand that I may revoke this authorization at any time by notifying First Step Foot Care in writing. However, if I choose to do this, I understand that my revocations do not affect any action taken by First Step Foot Care (FSFC) before receiving my notice. This authorization does not expire unless a request is made in writing.

Signature of patient or patient representative: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_