FAMILY Podiatry and Vein Care

Medical & Surgical Foot Specialist
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Family Podiatry, PA
HIPPA Medical Information Release Form

Authorization to Release Medical Information (Other than Patient)

I authorize the following person(s) to have access to my protected health information. This allows the mentioned person(s) to access my medical records and financial records for Family Podiatry, PA. I have listed their names and relationship to me. I understand that I have the right to limit the type of information that the listed individual(s) receive. I also understand that it is my responsibility to notify Family Podiatry, PA in writing, if any of the stated information on this form needs to be changed.

☐ No one at this time/Not Applicable

Name: _____ Relationship to Patient: _____

☐ Any/All Records

****OPTIONAL** If Limited Access**

Type of Information this Individual may receive:

_____

_____

Name: _____ Relationship to Patient: _____

☐ Any/All Records

****OPTIONAL** If Limited Access**

Type of Information this Individual may receive:

_____

_____

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May we leave a message on your HOME answering machine or cell phone voice mail if there is no answer?? MARK ONE ☐ YES ☐ NO

I hereby acknowledge that I have been presented with a copy of Family Podiatry's Notice of Privacy Practices and authorize the above listed person(s) (if any) access to my protected health information as stated above.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____

Todays Date: _____