BATAVIA FOOT CARE CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION
PERMISSION REGARDING COMMUNICATIONS

I hereby authorize BATAVIA FOOT CARE CENTER and/or staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it upon request.

PATIENT NAME:_____ DATE OF BIRTH:_____

PERSONS/ORGANIZATIONS YOU AUTHORIZE BATAVIA FOOT CARE CENTER TO RELEASE INFORMATION TO. Specific description of information to be used or disclosed includes the following: OFFICE NOTES, TEST RESULTS, MEDICATIONS, APPOINTMENTS & BILLING & CLAIM RECORDS. For LIFTEIME, unless otherwise stated.

PRIMARY CARE DOCTOR: _____

NAME OF OTHER MEDICAL DOCTORS _____

NAME OF INDIVIDUAL:_____ RELATIONSHIP:_____

TELEPHONE(S): HOME:_____ CELL:_____

NAME OF INDIVIDUAL:_____ RELATIONSHIP:_____

TELEPHONE(S): HOME:_____ CELL:_____

PLEASE ANSWER THESE QUESTIONS: Does the staff of Batavia Foot Care have your permission to communicate information regarding medications and/or appointments relating to above patient by leaving a message on:

HOME ANSWERING MACHINE:.....**YES NO** WITH ANOTHER PERSON.....**YES NO** WORK ANSWERING MACHINE.....**YES NO**

SEND VIA E-MAIL/PORTAL:....**YES NO** CELL PHONE VOICE MAIL:.....**YES NO** MOBILE TEXT.....**YES NO**

The patient or patient's representative must read the following statements & initial.

1. I understand that this authorization will expire on LIFETIME. Unless date otherwise stated:_____. **Initial:-**_____
2. I understand that I may revoke this authorization at any time by notifying Batavia Foot Care in writing, but if I do it won't have any effect on any actions taken before receipt of my revocation. **Initial:**_____
3. I understand that once Batavia Foot Care discloses my health information to the recipient indentified above, my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal & state law governing the use and disclosure of my health information. **Initial:**_____
4. I understand that digital images may be recorded to document my care, & I consent to this. I understand that Batavia Foot Care Center will retain ownership rights to these images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative. **Initial:**_____

Batavia Foot Care will not condition my treatment 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.

XX_____ _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE

Printed name of patient's representative (if applicable)_____

Relationship to the patient (if applicable)_____