Foot & Ankle Center of Washington
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AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize _____ [insert name of Doctor or Practice] and/or his/her/its 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 redisclosure by the recipient and may no longer be protected by federal or state law.

Patient name:_____ **Date of birth:**_____

Persons/organizations receiving the information: _____

_____

_____

Specific description of information to be used or disclosed (including date(s)): _____

_____

Section B: Must be completed only if a health plan or a health care provider has requested the authorization.

1. The health plan or health care provider must complete the following:
   a. What is the purpose of the use or disclosure:_____
   _____
   (no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose)
   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ____ No ____
2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials:_____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.
   Initials:_____

Section C: Must be completed for all authorizations

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

1. I understand that this authorization will expire on _ _ / _ _/_ _ _ _ (DD/MM/YYYY) Initials:_____
2. I understand that I may revoke this authorization at any time by notifying _____ [insert name of Practice] in writing, but if I do it won't have any affect on any actions taken before receipt of my revocation. Initials:_____

_____ [insert name of Doctor or Practice] 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.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my doctor from a third party. **[If applicable because the authorization is obtained for marketing purposes.]**

_____ _____

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

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

Relationship to the patient (if applicable):_____

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***