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DESOTO, TX 75115

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SUNNYVALE, TX 75182

3500 Oaklawn Ave #380
DALLAS, TX 75219

Authorization Form Requesting Release of Protected Health Information

Patient Name:_____ Date of Birth: _____

By signing this form, I authorize you to use and disclose the protected health information described below.

Information requested:_____

Release my protected health information to the following person(s)/entity:

Infinity Foot and Ankle, PA
2611 Bolton Boone Dr.
Desoto, Tx 75115

The reasons or purposes for this release of information are as follows:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to:

Practice Administrator
2611 Bolton Boone Dr.
Desoto, Tx 75115

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization is subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits on whether I provide ization for the requested use or disclosure.

Signature of Patient or Personal Representative Date:

_____ _____

Name of Patient or Personal Representative Relationship:

_____ _____