Foot Specialists of Kansas City, P.A.
www.kcfeet.com

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Authorization for the Disclosure of Protected Health Information

Patient Information:

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

I hereby authorize:

Person or Organization: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

To disclose or release to the following Persons or Organization listed below:

Person or Organization: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Information being requested:

Specify the dates or time period when known, from:_____ to: _____

☐ Clinic Notes, Lab & Test Results ☐ Confined to the following specified information: _____

Purpose or need for disclosure:

☐ Continuation of care ☐ Insurance Application ☐ Legal ☐ Personal ☐ Other

Please note the following:

You have the right to revoke this authorization at any time by notifying the Medical Records Department of Foot Specialists of Kansas City in writing. The revocation will be effective on the date notified and will not apply to all information that has already been released in response to this authorization. This authorization is valid for a year unless specified: _____

We may deny access to protected health information in certain situations and conditions. If you are denied access to any portion of the protected health information requested, we will notify you in writing of the reason for denial. We will also inform you of any rights you may have to have the denial reviewed. By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material to be disclosed. Copies of records may be obtained with a reasonable notice and payment of copying services.

Please allow up to 30 days to process this request

Signature of Patient: _____ Date: _____