MIDTOWN
7000 Euclid Avenue
Cleveland, Ohio 44102
216-231-5612
Fax: 216-721-5534

INDEPENDENCE
6000 Rockside Woods Blvd
Independence, Ohio 44131
216-643-8090
Fax: 216-447-4021

AUTHORIZATION FOR RELEASE OF INFORMATION

Medical Record # _____________

I hereby authorize the Cleveland Foot and Ankle Clinic to disclose my protected 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 laws. 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. I understand that I may revoke this authorization at any time by giving notice in writing to the address found above, but if I do, it will not affect any actions taken before the receipt of my revocation.

I understand that my treatment will not be conditioned 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.

Name of Patient: ______________________________ **Date of Birth:** ____________________

Persons/Organization to be released/disclosed is specified below:

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The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record or specify one or more of the following:**

☐ **Operative Reports** ☐ **X-Rays**

☐ **Progress Notes** ☐ **Billing and Claim records**

☐ **Laboratory** ☐ **(Other- Specify)**

This information is to be used/disclosed for the following purpose(s) only:

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(no purpose need to be stated if the request is made by the patient and the patient doesn't wish to state the purpose).

This authorization will expire on: ______________________________ (specify date or event)

______________________________________ ____________________

Signature of patient or patient representatives Date

(Form must be completed before signing.)

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

Relationship to patient (if applicable): ______________________________