

# Ankle & Foot Clinic of Everett

## Authorization for REQUEST of information

- Jeffrey Christensen, DPM, FACFAS
- Mary Crawford, DPM, FACFAS
- Cherie Johnson, DPM, FACFAS
- Robert Stanton, DPM

3131 Nassau Ave, #101, Everett WA 98201  
Phone (425) 339-8888 Fax (425) 258-6933

PATIENT NAME: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_

DATE OF BIRTH: (mm/dd/yy) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAY PHONE: (\_\_\_\_\_) \_\_\_\_\_ EVENING PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_\_) \_\_\_\_\_

### I HEREBY AUTHORIZE

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

To release information from my medical records as indicated below to:

### **Ankle & Foot Clinic of Everett (See address & fax number above)**

#### INFORMATION REQUESTED:

- History and Physical: \_\_\_\_\_ Dates: \_\_\_\_\_
- Progress notes \_\_\_\_\_ Dates: \_\_\_\_\_
- Lab reports \_\_\_\_\_ Dates: \_\_\_\_\_
- X-ray reports \_\_\_\_\_ Dates: \_\_\_\_\_
- Other: \_\_\_\_\_ Dates: \_\_\_\_\_
- Any information regarding \_\_\_\_\_

I specifically authorize the release of information relating to:

- Substance abuse (including alcohol/drug abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GAURDIAN DATE

**PURPOSE OF DISCLOSURE:**  Changing Physicians  Consultation/second opinion  Legal

Continuing care  Insurance  Disability  Workers Compensation  School

Other \_\_\_\_\_

I understand that this authorization will expire on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (print the date you want this form to expire)

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

I understand that if I am being requested to release this information by **Ankle & Foot Clinic of Everett** for the purpose of \_\_\_\_\_ by authorizing this information, my health care and payment for my health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I will get a copy of this form after I sign it. I have been informed that \_\_\_\_\_ will not receive financial or in-kind compensation in exchange for using or disclosing the health care information described above.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON

\_\_\_\_\_  
DATE

Copy of form:  given to patient  patient declined / Employee initials \_\_\_\_\_

#### FOR OFFICE USE ONLY

DATE REQUEST FILLED: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ BY \_\_\_\_\_ IDENTIFICATION PRESENTED: \_\_\_\_\_ FEE COLLECTED: \_\_\_\_\_