North Oakland Foot & Ankle

Release of Protected Health Information ("PHI"):

I authorize the release of PHI such as my medical records and information about my appointments, tests, treatments, and / or other information pertinent to my healthcare or payment provided

1. Any insurance carrier, workman's compensation or agency (social welfare, governmental) responsible for all or any part of charges and / or professional fees.
2. Any physician or health care facility as may be needed for any treatment and care.
3. An employer or any other entity authorized to approve or disapprove disability benefits.
4. The following individuals / organizations:

The release of PHI to the individuals / organization listed above **will not** include the following information unless the appropriate box is checked:

☐ Any records of treatment for drug and / or alcohol dependency or abuse.

☐ Any record of mental health treatment, psychological services, social services, including communications made to a social worker or psychologist.

☐ Any record of testing, care, treatment or research pertaining to HIV, AIDS or other communicable diseases.

Confidential Communications: (You may ask us to contact you or your designee at alternative locations.)
(Any individual or facility who you wish to have access to your medical records, please list below)

Name: _____ Relationship: _____ Date of Birth:_____

Address: _____

Name: _____ Relationship: _____ Date of Birth:_____

Address: _____

_____

Print Patient Name

_____ _____

Signature of Patient or Guardian **Date**