

More Than Just Podiatry

Office of James D. Sills-Powell, DPM

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Authorization for Use or Disclosure of Protected Health Information

Name of Patient: _____

Date of Birth: _____

Social Security #: _____

Contact: _____

Address: _____

Street

City/State

Zip Code

I, _____ hereby authorize **MORE THAN JUST PODIATRY** to disclose my medical records as indicated below to:

Name of Company/Provider/Individual

Address

City, State

Zip Code

Specific information to be released:

- Office Visits
- Lab Reports
- X-Ray Reports
- Consult Reports
- Operative Reports
- Other _____

My purpose/use of the information:

- Changing physicians
- Continuing care
- At my () request
- Workers' Compensation
- Other _____
- 2nd Opinion
- Legal
- Insurance
- School

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION * _____

NO, DO NOT DISCLOSE THIS INFORMATION * _____

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient/facility receiving it, and would then no longer be protected by Federal privacy regulations.

I may revoke this authorization by notifying **More Than Just Podiatry** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that this authorization will expire on _____ OR 6 months from date of release. A photocopy of this form will be considered as valid as the original.

By signing below, I acknowledge that I have read and understand this Authorization.

* _____
Signature of Patient/Legal Guardian

Relationship to Patient

Date

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING - note that signature is required in two places.

Federal/state laws permit a fee to be charged for the copying of patient records. Fee of \$25.00 is to be paid at the time of collection. Based on HB 351, new maximum fees for copying will be \$24.85 plus \$0.57 per page for the cost of labor and supplies for copies provided in paper form and \$23.26 for additional costs if records are maintained off-site. Based on HB 351, the new maximum fees for copying will be \$24.85 plus \$0.57 per page, or \$108.88 total, whichever is less, for copies provided electronically.

Records Received By

Date

For Office Use Only

Date Request Filled: _____

By _____

Patient Account # _____

Photo ID Presented: _____

Fee: \$25.00