PURVIS-MOYER FOOT & ANKLE CENTER

3301 Sunset Avenue, Rocky Mount, NC 27804

Authorization to Disclose Health Information

Patient:_____ DOB: _____ Chart #:_____

I request that my health information be disclosed:

○ To: _____

_____

○ From:_____

_____

By: ○ Mail ○ Fax _____

○ I authorize Purvis-Moyer Foot & Ankle Center to give verbal information only regarding my treatment to the above person/s.

Date(s) of record to be released from: _____ to _____

○ Entire Medical Record
○ Laboratory Report
○ Billing Record
○ Operative Report
○ XRay disk
○ Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the office. I understand that the revocation will not apply to information already released. This authorization will expire 12 months from the date of my signature.

I understand that authorizing this disclosure of health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. **I understand that a fee may be charged.**

Purvis-Moyer Foot & Ankle Center, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian/ Personal Representative Signature Date

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