PORTAGE FOOT CLINIC

Form 18 - AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

SECTION A: I authorize the disclosure of my personal health information as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I hereby give my permission to PORTAGE FOOT CLINIC to disclose my personal health information in the manner described herein.

Name: _____

Address: _____

Telephone: _____

SECTION B: Personal Health Information to Be Disclosed: Describe the personal health information you are authorizing to be used and/or disclosed:

_____

_____

_____

Persons/Entities Authorized to Receive and Use: Name or specifically describe the persons and/or entities to whom you are authorizing PORTAGE FOOT CLINIC to disclose or let use the personal health information described above:

_____

_____

_____

Purpose of the Disclosure: The disclosure is being made for the following reason:

_____

_____

_____

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this authorization will expire one (1) year after the date on which the authorization is signed. To revoke the authorization, I will contact Olga Carrillo, **c/o PORTAGE FOOT CLINIC.**

SIGNATURE: _____
I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to PORTAGE FOOT CLINIC. I understand that, by signing this form, I am confirming my authorization that PORTAGE FOOT CLINIC may use and/or disclose to the persons and/or organizations named in this form the nonpublic personal health information described in this form.

SIGNATURE: _____

Date: _____

Witness: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____