FOUNDATION
FOOT & ANKLE
SPECIALISTS

www.FoundationFoot.com

Auburn
206 Auburn Ave. | Auburn, WA 98002
ph 253.245.9299 | fax 253.604.1259

Tacoma
4050 S 19th St. #202 | Tacoma, WA 98405
ph 253.565.3355 | fax 253.564.6744

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize Foundation Foot and Ankle Specialists, PLLC and their providers to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

I, _____ (D.O.B. _____) authorize my health care information to be released to the following recipient(s):

Name: _____ Email: _____

Address: _____

Phone: _____ Fax: _____

Purpose: I authorize the release of my health information for the following specific purpose:

- ☐ For PCP or other coordinating physician
- ☐ 2nd Opinion
- ☐ At my request
- ☐ Other: _____

Information to be disclosed: I authorize the release of the following health information:

- ☐ All my health information
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information covering the period from: _____ to _____
- ☐ Other: _____

Term: I understand that this Authorization will remain in effect:

- ☐ Until the Provider fulfills this request.
- ☐ Until the following date: _____
- ☐ Until the following event occurs: _____

My Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

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I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

_____ _____

Signature Date

If Individual is a minor or unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name of Guardian/Representative Legal Relationship Date