NORTHWEST FOOT & ANKLE CENTER, PS

NORTHWEST FOOT
AND ANKLE CENTER

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MEDICAL INFORMATION RELEASE

I, THE UNDERSIGNED PATIENT, UNDERSTAND THAT AS A PATIENT OF NORTHWEST FOOT AND ANKLE CENTER, THAT MY PATIENT HEALTH INFORMATION (PHI) MAY BE REVEIWED BY PHYSICIANS OR MEDICAL PROVIDERS OTHER THAN MY IMMEDIATE PHYSICIAN, TO INCLUDE BUT NOT RESTRICTED TO MY PRIMARY CARE PHYSICIAN, AND ANY REFERRAL PHYSICIANS OR PROVIDERS DEEMED BY MY PHYSICIAN TO BE INSTRUMENTAL IN MY CARE.

PLEASE CHECK ONE OF THE FOLLOWING BOXES:

[] BY MY SIGNATURE BELOW, I **AUTHORIZE** THE SHARING OF MY PATIENT HEALTH INFORMATION AS DESCRIBED ABOVE. AT THE DISCRETION OF THE PHYSICIANS OF NORTHWEST FOOT AND ANKLE CENTER, FOR TREATMENT PURPOSES ONLY.

[] BY MY SIGNATURE BELOW, I **REFUSE AUTHORIZATION** TO RELEASE OR SHARE MY PATIENT HEALTH INFORMATION WITH ANY SOURCE OUTSIDE NORTHWEST FOOT AND ANKLE, EXCEPT AS NECESSARY FOR INSURANCE REIMBURSEMENT.

PLEASE CHECK ONE OF THE FOLLOWING BOXES:

[] BY MY SIGNATURE BELOW, I **AUTHORIZE** THE OFFICE TO LEAV MESSAGES ON MY ANSWERING MACHINE OR SPEAK WITH ANOTHER FAMILY MEMBER AT MY HOME REGARDING PRESCIPTIONS, APPOINTMENTS OR TEST RESULTS.

[] BY MY SIGNATURE BELOW, I **REFUSE AUTHORIZATION** TO LEAVE MESSAGES ON MY MACHINE OR ANSWERING SERVICE, OR WITH A FAMILY MEMBER AT MY HOME ABOUT ANYTHING OTHER THAN TO RETURN YOUR CALL.

ALTERNATE PHONE NUMBER:______________________________

PATIENT NAME:____

PATIENT SIGNATURE:______________________________________

WITNESS:____________________________ DATE:_______________