Associated Foot Surgeons
Drs. Watson & Dabdoub
108 Smart Place Slidell, LA 70458
1018 6th Avenue Picayune, MS 39466

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Associated Foot Surgeons to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name:____________________________________ **Date of birth:**______________________

Doctor/Hospital/Facility/Person/Organization to receive the information:

1.____________________________________ **Relationship:**______________________
2.____________________________________ **Relationship:**______________________
3.____________________________________ **Relationship:**______________________

The specific information to be released/disclosed is specified below:

☐ **Complete Medical Record**

Or specify one or more of the following:

☐ Operative Reports	☐ X-rays
☐ Progress Notes	☐ Billing and Claim Records
☐ Laboratory	☐ (Other – specify) _______________

This information is to be used/disclosed for the following purposes(s) only: ______________________________

____

This authorization will expire on ____ Date:__________

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ **Yes** ☐ **No** ______ **Initials**

____ ____________________
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):__________________________________
Relationship to the patient (if applicable):____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT***

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient:____**Date of Birth**_____________

I request that all communications to me (by telephone, mail or otherwise) by Associated Foot Surgeons be handled in the following manner:

* For written communications: Address to: ____

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* For oral communications: Call: ____

(Telephone number)
May we leave a message?

Yes ☐ No ☐

I give permission for you to speak with the following person(s)with regards to my treatment and billing:

1. ____Relationship:__________________________
2. ____Relationship:__________________________

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

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RESTRICTION REQUEST FORM

For Use and Disclosure of Patient Health Information

In completing this form, you are requesting that the following restrictions and limitations to the use and disclosure of your protected health information.

Requested Restrictions (please provide specific details and dates):

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so chose and understood the Notice.

____

Patient Name

____/_____________________________/_____________

Signature of Patient or Authorized Person **Relationship** **Date**