The Foot and Ankle Wellness Center of Western Pennsylvania

Authorization to Use or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name:	Date of Birth:	Social Security Number:
Address (Street, City, State, Zip Code):		Telephone Number:

The following individual or organization is authorized to make the disclosure:

- The Foot and Ankle Wellness Center of Western Pennsylvania
- Other (Please Specify):____________________

Treatment Dates:	Purpose of Request:

The following information is to be disclosed (Please check one box for each item):

Yes	No		Dates:
☐	☐	Physician Notes:	____________________
☐	☐	Lab Results:	____________________
☐	☐	X-Ray Reports:	____________________
☐	☐	MRI Reports:	____________________
☐	☐	Cardiac Reports:	____________________
☐	☐	Complete Records	____________________
☐	☐	Other:	____________________

Sensitive Information:
I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure:
I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

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Initials

Ford City Location
313 Ford Street
Ford City, PA 16226
P: (724) 763-4080
F: (724) 763-4083

Butler Location
100 Evans Road
Butler, PA 16001
P: (724) 841-0188
F: (724) 841-0189
Toll Free: (844)-FOOTDOC (366-8375)

Monaca Location
3578 Brodhead Road
Monaca, PA 15061
P: (724) 775-6168
F: (724) 775-2633

Grove City Location
675 N. Broad Street Ext, Suite 2
Grove City, PA 16127
P: (724) 450-1144
F: (724) 450-1140

www.fawcpa.com

The Foot and Ankle Wellness Center of Western Pennsylvania

Right to Revoke:
I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. Also, I understand that revocation will not apply to information already released based on this authorization.

Other Rights:
a. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
b. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration:
Unless otherwise revoked, this authorization will expire on the following date, event, or condition. (If I do not specify an expiration date, event, or condition this authorization expires in 6 (six) months)

____
Signature of Patient or legal Representative

____
Date

____
Print Name

____
If signed by a Legal Representative, Relationship to Patient