Newport Family Podiatry
Michael J Hattan, D.P.M.
355 Placentia Ave., Suite 101
Newport Beach, CA 92663
P: (949) 650-1900 ● F: (949) 650-1902

Authorization for Release of Information

I hereby authorize NEWPORT FAMILY PODIATRY 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 redisclosure 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, and that I will receive a copy of this form after I sign 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 request us or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to e solely for the purpose of creating protected health information for disclosure to a third party.

Name of Patient ______________________ Street Address ______________________

Phone Number ______ Fax Number ______ City ______ State ______ Zip Code ______

Email Address (please print clearly) ______________________ Date of Birth (00/00/0000) ______________________

I authorize the records to be released to the following Persons/Organization/Entity:

□ Provider □ Insurance □ Patient

Name ______________________ Street Address ______________________

Phone Number ______ Fax Number ______ City ______ State ______ Zip Code ______

I hereby give the following entity permission to release my Protected Health Information (PHI):

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

□ Complete Medical Record

Or Specify one or more of the following:

□ Operative Reports
□ Progress Notes
□ Laboratory
□ X-rays
□ Billing and Claims Records
□ (Other – specify)__________________

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

____
(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on ________________________________ (state date or event).

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

____ ________________
Print Name Signature of Patient Date

____ ________________
Signature of Parent/Guardian or Personal Representative (attach proper documentation) Date

YOU ARE ENTITTLED TO A COPY OF THIS DOCUMENT